DEPARTMENT OF HEALTH AND HUMAN SERVICES

Centers for Medicare & Medicaid Services

42 CFR Part 416

[CMS-1478-IFC]

Medicare Program; Update of Ambulatory Surgical Center List of Covered Procedures

AGENCY: Centers for Medicare & Medicaid Services (CMS), HHS.

ACTION: Interim final rule with comment period.

SUMMARY: This interim final rule with comment period revises the list of procedures that are covered when furnished in an ambulatory surgery center (ASC) in accordance with section 1833(i)(1) of the Social Security Act. We published our proposed deletions and additions in the **Federal Register** on November 26, 2004.

In this interim final rule, we respond to public comments and make final additions to and deletions from the current list of Medicare approved ambulatory surgical center (ASC) procedures.

DATES: Effective date: These regulations are effective on July 5, 2005.

Comment date: To be assured consideration, comments must be received at one of the addresses provided below, no

later than 5 p.m. on **[**OFR--insert date 60 days after date of publication in the **Federal Register]**.

ADDRESSES: In commenting, please refer to file code CMS-1478-IFC. Because of staff and resource limitations, we cannot accept comments by facsimile (FAX) transmission.

You may submit comments in one of three ways (no duplicates, please):

1. Electronically. You may submit electronic comments on specific issues in this regulation to http://www.cms.hhs.gov/regulations/ecomments. (Attachments should be in Microsoft Word, WordPerfect, or Excel; however, we prefer Microsoft Word.)

2. By mail. You may mail written comments (one original and two copies) to the following address ONLY:

Centers for Medicare & Medicaid Services,

Department of Health and Human Services,

Attention: CMS-1478-IFC,

P.O. Box 8017,

Baltimore, MD 21244-8017.

Please allow sufficient time for mailed comments to be received before the close of the comment period.

3. By hand or courier. If you prefer, you may deliver (by hand or courier) your written comments (one original

and two copies) before the close of the comment period to one of the following addresses. If you intend to deliver your comments to the Baltimore address, please call telephone number (410) 786-7195 in advance to schedule your arrival with one of our staff members.

Room 445-G, Hubert H. Humphrey Building,
200 Independence Avenue, SW.,
Washington, DC 20201; or

7500 Security Boulevard,
Baltimore, MD 21244-1850.

(Because access to the interior of the HHH Building is not readily available to persons without Federal Government identification, commenters are encouraged to leave their comments in the CMS drop slots located in the main lobby of the building. A stamp-in clock is available for persons wishing to retain a proof of filing by stamping in and retaining an extra copy of the comments being filed.)

Comments mailed to the addresses indicated as appropriate for hand or courier delivery may be delayed and received after the comment period.

For information on viewing public comments, see the beginning of the "SUPPLEMENTARY INFORMATION" section.

FOR FURTHER INFORMATION CONTACT:

Dana Burley, (410) 786-0378.

SUPPLEMENTARY INFORMATION:

Submitting Comments: We will consider comments from the public regarding the addition of procedures to the ASC list, deletion of procedures from the ASC list, and the ASC payment group assignment for newly-added procedures that are identified with an asterisk in Addendum A to signify that the procedure was not proposed for addition or deletion in the November 26, 2004 rule. You can assist us by referencing the file code CMS-1478-IFC and the specific "issue identifier" that precedes the section on which you choose to comment.

Inspection of Public Comments: All comments received before the close of the comment period are available for viewing by the public, including any personally identifiable or confidential business information that is included in a comment. We post all electronic comments received before the close of the comment period on its public website as soon as possible after they have been received. Hard copy comments received timely will be available for public inspection as they are received, generally beginning approximately 3 weeks after publication of a document, at the headquarters of the Centers for

Medicare & Medicaid Services, 7500 Security Boulevard, Baltimore, Maryland 21244, Monday through Friday of each week from 8:30 a.m. to 4 p.m. To schedule an appointment to view public comments, phone 1-800-743-3951.

I. Background

[If you choose to comment on issues in this section, please include the caption “BACKGROUND” at the beginning of your comments.]

A. Legislative History

Section 1832(a)(2)(F)(i) of the Social Security Act (the Act) provides that benefits under the Medicare Supplementary Medical Insurance program (Part B) include payment for facility services furnished in connection with surgical procedures we specify and which are performed in an ambulatory surgical center (ASC). To participate in the Medicare program as an ASC, a facility must meet the standards specified in section 1832(a)(2)(F)(i) of the Act; in 42 CFR 416.25, which sets forth general conditions and requirements for ASCs; and, in 42 CFR 416, subpart C, which provides specific conditions for coverage for ASCs.

There are two primary elements in the total cost of performing a surgical procedure--the cost of the physician's professional services in performing the

procedure and the cost of items and services furnished by the facility where the procedure is performed (for example, surgical supplies and equipment and nursing services). This interim final rule with comment period addresses the second element, the coverage and payment of facility fees for ASC services under the current payment system. As we note below, section 626(b) of the Medicare Prescription Drug, Improvement, and Modernization Act of 2003 (MMA) (Pub. L. 108-173, enacted on December 8, 2003) requires that we develop a revised payment system for ASC facility services that would be implemented no earlier than January 1, 2006. This interim final rule addresses additions to and deletions from the list of Medicare approved ASC procedures before the implementation of that revised payment system.

Under the current ASC facility services payment system, the ASC payment rate is a standard overhead amount established on the basis of our estimate of a fair fee that takes into account the costs incurred by ASCs generally in providing facility services in connection with performing a specific procedure. The report of the Conference Committee accompanying section 934 of the Omnibus Budget Reconciliation Act of 1980 (OBRA)(Pub. L. 96-499), which

enacted the ASC benefit in December 1980, states that this overhead factor is expected to be calculated on a prospective basis using sample survey and similar techniques to establish reasonable estimated overhead allowances, which take account of volume (within reasonable limits), for each of the listed procedures. (See H.R. Rep. No. 96-1479, at 134 (1980)).

To establish those reasonable estimated allowances for services furnished before implementation of the revised payment system mandated by the MMA, section 626(b)(1) of the MMA amended section 1833(i)(2)(A)(i) of the Act to require us to take into account the audited costs incurred by ASCs to perform a procedure, in accordance with a survey. Payment for ASC facility services is subject to the usual Medicare Part B deductible and coinsurance requirements, and the amounts paid by Medicare must be 80 percent of the standard fee.

Section 1833(i)(1) of the Act requires us to specify, in consultation with appropriate medical organizations, surgical procedures that can be safely performed in an ASC and to review and update the list of ASC procedures at least every two years.

Section 141(b) of the Social Security Act Amendments of 1994 (SSAA 1994) requires us to establish a process for reviewing the appropriateness of the payment amount provided under section 1833(i)(2)(A)(iii) of the Act for intraocular lenses (IOLs) for a class of new-technology IOLs. That process was the subject of a separate final rule entitled "Adjustment in Payment Amounts for New Technology Intraocular Lenses Furnished by Ambulatory Surgical Centers," published on June 16, 1999 in the **Federal Register** (64 FR 32198).

B. Summary of Updates of the ASC List

Section 934 of the Omnibus Budget Reconciliation Act of 1980 amended sections 1832(a)(2) and 1833 of the Act to authorize the Secretary to specify surgical procedures that, although appropriately performed in an inpatient hospital setting, can also be performed safely on an ambulatory basis in an ASC, a hospital outpatient department, or a rural primary care hospital. The report accompanying the legislation explained that the Congress intended procedures currently performed on an ambulatory basis in a physician's office that do not generally require the more elaborate facilities of an ASC not be included in the list of covered procedures (H.R. Rep. No. 96-1167, at

390, reprinted in 1980 U.S.C.C.A.N. 5526, 5753). In a final rule published August 5, 1982 in the **Federal Register** (47 FR 34082), we established regulations that included criteria for specifying which surgical procedures were to be included for purposes of implementing the ASC facility benefit.

Subsequently, in accordance with §416.65(c), we published an update of the ASC list in the **Federal Register** on March 28, 2003 (68 FR 15268).

During years when we do not update the list in the **Federal Register**, we revise the list to be consistent with annual calendar year changes in codes established by the American Medical Association (AMA) Current Procedural Terminology (CPT), removing from the ASC list codes that are deleted by CPT and adding new codes that replace codes already on the ASC list. These annual CPT updates are implemented through program instructions to carriers who process ASC claims.

C. Regulatory Requirements

1. Sections 416.65(a), (b), and (c)

Section 416.65(a) specifies general standards for procedures on the ASC list. ASC procedures are those surgical and medical procedures that are--

- Commonly performed on an inpatient basis but may be safely performed in an ASC;
- Not of a type that are commonly performed or that may be safely performed in physicians' offices;
- Limited to procedures requiring a dedicated operating room or suite and generally requiring a post-operative recovery room or short term (not overnight) convalescent room; and
- Not otherwise excluded from Medicare coverage.

Specific standards in §416.65(b) limit ASC procedures to those that do not generally exceed 90 minutes operating time and a total of 4 hours recovery or convalescent time. If anesthesia is required, the anesthesia must be local or regional anesthesia, or general anesthesia of not more than 90 minutes duration.

Section 416.65(c) excludes from the ASC list procedures that generally result in extensive blood loss, that require major or prolonged invasion of body cavities, that directly involve major blood vessels, or that are generally emergency or life-threatening in nature.

2. Criteria for Additions to or Deletions from the ASC List

In April 1987, we adopted quantitative criteria as tools for identifying procedures that were commonly performed either in a hospital inpatient setting or in a physician's office. Collectively, commenters responding to a notice published on February 16, 1984 in the **Federal Register** (49 FR 6023) had recommended that virtually every surgical CPT code be included on the ASC list. Consulting with other specialist physicians and medical organizations as appropriate, our medical staff reviewed the recommended additions to the list to determine which code or series of codes were appropriately performed on an ambulatory basis within the framework of the regulatory criteria in § 416.65. However, when we arrayed the proposed procedures by the site where they were most frequently performed according to our claims payment data files (1984 Part B Medicare Data (BMAD)), we found that many codes were not commonly performed on an inpatient basis or were performed in a physician's office the majority of the time, and, thus, would not meet the standards in our regulations. Therefore, we decided that if a procedure was performed on an inpatient basis 20 percent of the time or less, or in a physician's office 50 percent of the time or more, it would

be excluded from the ASC list. (See **Federal Register** April 21, 1987 (52 FR 13176).)

At the time, we believed that these utilization thresholds best reflected the legislative objectives of moving procedures from the more expensive hospital inpatient setting to the less expensive ASC setting without encouraging the migration of procedures from the less expensive physician's office setting to the ASC. We applied these quantitative standards not only to codes proposed for addition to the ASC list, but also to the codes that were currently on the list, to delete codes that did not meet the thresholds.

The trend towards performing surgery on an ambulatory or outpatient basis grew steadily, and by 1995, we discovered that a number of procedures that were on the ASC list at the time fell short of the 20 percent and 50 percent thresholds even though the procedures were obviously appropriate in the ASC setting. The most notable of these was cataract extraction with intraocular lens insertion, very few cases of which were being performed on an inpatient basis by the early 1990s. The thresholds would also have excluded from the ASC list certain newer procedures, such as CPT code 66825, Repositioning of

intraocular lens prosthesis, requiring an incision (separate procedure), that were rarely performed on a hospital inpatient basis but that were appropriate for the ASC setting. Strict adherence to the same 20 percent and 50 percent thresholds both to add and remove procedures did not provide latitude for minor fluctuations in utilization across settings or errors that could occur in the site-of-service data drawn from the National Claims History File that we were then using, replacing BMAD data, for analysis.

In an effort to avoid these anomalies but still retain a relatively objective standard for determining which procedures should comprise the ASC list, we adopted in the **Federal Register** notice published on January 26, 1995 (60 FR 5185) a modified standard for deleting procedures already on the list. We deleted from the list only those procedures whose combined inpatient, hospital outpatient, and ASC site of service volume was less than 46 percent of the procedure’s total volume and that were either performed 50 percent of the time or more in the physician’s office or 10 percent of the time or less in an inpatient hospital setting. We retained the 20 percent and 50 percent standard to determine which procedures would be appropriate additions to the ASC list.

D. Office of the Inspector General Recommendations, January 2003

In January 2003, the Office of the Inspector General (OIG) issued the results of a study entitled "Payments for Procedures in Outpatient Departments and Ambulatory Surgical Centers" (OEI-05-00-00340). The objective of that study was to determine the extent to which Medicare payments for the same procedures continue to vary between hospital outpatient departments and ambulatory surgical centers and to assess the effect of this variance on the Medicare program.

The OIG concluded, as a result of its study, that there should be a greater parity of payments for services performed in an outpatient setting and those performed in ASCs. The OIG based this conclusion both on its belief that the Congress intended Medicare to be a prudent purchaser of services and to pay only for those costs that are necessary for the efficient delivery of needed health services and on its finding that disparities in Medicare payment amounts for the same services furnished in ASCs and hospital outpatient departments resulted in an estimated $1.1 billion in additional Medicare program payments. The OIG also found that our failure to remove certain procedure

codes from the list of ASC-approved procedures resulted in an estimated $8 to $14 million in additional Medicare program payments.

The OIG recommended that we--

- Seek authority to set rates that are consistent across sites and reflect only the costs necessary for the efficient delivery of health services;
- Conduct surveys and use timely ASC survey data to reevaluate ASC payment rates; and
- Remove the procedure codes that meet our criteria for removal from the ASC list of covered procedures. (In its final report, the OIG included a list of 72 CPT codes that it found, based on its analysis of calendar year 1999 data, met our criteria for deletion from the ASC list.)

In our response to the OIG's recommendations, we indicated that we would consider the OIG's first recommendation as we develop future legislative proposals. In response to the second recommendation, we indicated our concerns about using survey data as the basis for setting ASC payment rates and that we were considering how to implement the survey requirement. (Enactment of section

626(b) of the MMA repealing the survey requirement and mandating implementation of a revised payment system in accordance with certain requirements set forth in the MMA supersedes our earlier response to this OIG recommendation.)

E. Current ASC Payment Rates

Procedures on the ASC list are assigned to one of nine payment groups based on our estimate of the costs incurred by the facility to perform a procedure. Payment groups 1 through 8 were first implemented in September 1990, based on a survey of ASC costs conducted in 1986 (55 FR 4539). Payment group 9 was added on December 31, 1991 (56 FR 67666) to establish a payment rate for extracorporeal shockwave lithotripsy (ESWL). There is no clinical consistency among the procedures in a payment group. Rather, assignment to a payment group is based solely on an estimate of facility costs associated with performing the procedures.

In a proposed rule published on June 12, 1998 in the **Federal Register** (63 FR 32290), we proposed a new ratesetting methodology based on ambulatory payment classification (APC) groups that were proposed for the new hospital outpatient prospective payment system (OPPS). We

used data from a survey of ASC costs collected in 1994 as the basis for the APC payment rates in the June 12, 1998 proposed rule. The Balanced Budget Refinement Act of 1999 (BBRA) (Pub. L. 106-113) required us to phase in full implementation of the proposed ASC rates over a 3-year period. The Medicare, Medicaid, and SCHIP Benefits Improvement and Protection Act of 2000 (BIPA) (Pub. L. 106-554) prohibited implementation of a revised prospective payment system for ASCs before January 1, 2002 and required that, by January 1, 2003, ASC rates be rebased using data from a 1999 or later Medicare survey of ASC costs.

We discuss in the final rule published on March 28, 2003 in the **Federal Register** (68 FR 15270) the reasons why we did not implement the requirements set forth in BBRA and BIPA with regard to rebasing ASC payment rates. The March 28, 2003 final rule with comment period implemented additions to and deletions from the ASC list that had been proposed in the June 12, 1998 proposed rule, but did not implement any of the other proposed changes, including the proposed ratesetting methodology. We indicated that we were studying approaches to ratesetting, some of which may require legislative changes.

Section 626(b) of MMA repeals the requirement that we conduct a survey of ASC costs as the basis for rebasing ASC rates and requires us to implement a revised payment system between January 1, 2006 and January 1, 2008, that takes into account recommendations in the report to the Congress that was to be submitted by January 1, 2005 by the Comptroller General of the United States. Since section 626(b)(1) amends section 1833(i)(2) of Act, we are required to base payment for ASC services on survey data before implementation of the revised payment system. Therefore, the additions to the ASC list in this interim final rule are assigned to one of the existing nine ASC payment groups and rates that are derived from data collected in the 1986 survey of ASC costs, updated for inflation. The payment group for each addition to the ASC list in this interim final rule is based on the payment group to which procedures currently on the list, which our medical advisors judged to be similar in terms of time and resource inputs, are assigned. As of April 1, 2004, in accordance with the requirements in section 626(a) of MMA and instructions that we issued to our contractors who process ASC claims in Transmittal 51, Change Request 3082, on February 6, 2004, the ASC payment rates are the following:

Group 1	$333
Group 2	$446
Group 3	$510
Group 4	$630
Group 5	$717
Group 6	$826($676 plus $150 for IOL)
Group 7	$995
Group 8	$973($823 plus $150 for IOL)
Group 9	$1339

F. Summary of the Provisions of the Proposed Rule

In the November 26, 2004 proposed rule, we proposed to delete 54 procedures from the ASC list based on the OIG recommendations. An additional 46 deletions were proposed based on data that indicated that either the physician office or the inpatient setting was the predominant site of service or based on recommendations from specialty organizations that there were beneficiary safety concerns associated with furnishing the procedure(s) in the ASC.

We also proposed to add to the list 25 procedures that were recommended by commenters and other interested parties.

II. Analysis of and Responses to Public Comments Received on the November 26, 2004 Proposed Rule and Provisions of This Interim Final Rule With Comment Period

[If you choose to comment on issues in this section, please include the caption "ANALYSIS OF AND RESPONSES TO PUBLIC COMMENTS RECEIVED ON THE NOVEMBER 26, 2004 PROPOSED RULE AND PROVISIONS OF THIS INTERIM FINAL RULE WITH COMMENT PERIOD" at the beginning of your comments.]

A. General Comments

Summaries of the public comments and our responses to those comments are set forth in the various sections of this preamble under the appropriate headings.

We received a number of general public comments on our proposed changes to the ASC list.

Comment: The comments we received expressed opposition to our proposed deletions. Although we received many comments requesting that we not delete specific procedures, we also received many from individual physicians, ASCs, professional and trade associations, and medical societies and organizations expressing their belief

that our proposed deletion of 100 procedures from the ASC list was misguided. The overwhelming response from the public was that there are many beneficiaries for whom the ASC setting is the safest and most appropriate setting for a number of surgical procedures. The commenters were especially concerned about our proposals to delete procedures based on either the OIG recommendations or high physician office utilization.

They stated that there were several detrimental effects that would likely result from deletion of the codes as proposed. They believe that deleting the procedures will result in beneficiaries' decreased access to the most appropriate care, increased costs for the Medicare program and for beneficiaries because the procedures will have to be furnished in the more costly hospital outpatient department if the ASC is not an option, and creation of incentives to perform procedures in inappropriate settings.

Response: As will be discussed in more detail in other sections of this interim final rule, we recognize the validity of the arguments and clinical evidence that was provided to us by commenters. As a result, we will delete fewer procedures from the ASC list than we proposed.

Comment: We also received a number of comments that expressed disappointment that we have not adopted new criteria for determining which procedures are to be included on the ASC list. The commenters stated that the current criteria are obsolete and are in need of updating to account for new clinical practices and technological advances. Furthermore, many commenters objected to having an ASC list of procedures. They believe that we should adopt an exclusionary list instead.

Response: We are embarking on development of a new payment system as mandated by section 626 of the MMA. As part of that process, we will review the criteria for determining which procedures are eligible for inclusion on the ASC list.

Comment: We received several comments that expressed doubt about our proposals for ASC list additions and deletions based on reimbursement. The commenters believe that we are overstepping our authority in considering payment levels before we add codes to the ASC list. Specifically, they use as an example our decision to exclude from the ASC list procedures that would be paid significantly more by Medicare under the ASC payment system

than they are currently being paid under the hospital outpatient prospective system.

Response: As discussed in our March 28, 2003 final rule (68 FR 15270), we do not add procedures to the lowest ASC payment group that would be paid significantly more in an ASC than the same procedure is paid in the hospital outpatient department. We believe that our process is consistent with the law and its intent. The legislative history of section 934 of the Omnibus Reconciliation Act of 1980 (Pub. L. 96-499), which created the ASC benefit, indicates congressional intent to encourage performance of surgery in lower cost settings. Thus, we believe it is antithetical to the statutory mandate to create incentives which could shift those procedures to an ASC setting for increased Medicare payment. Similarly, we try not to add procedures to the list that would be significantly underpaid in the highest ASC payment group.

In the June, 1998 proposed rule, we proposed the addition of CPT code 50590, Extracorporeal shock wave lithotripsy to what would have been the highest payment group. The American Lithotripsy Society disagreed with the addition payment rate and, through litigation, avoided that addition. We now are embarking on development of a new

payment system for ASCs, and so are not adopting any revisions to our rate-setting method before that development. At this time, we are updating the list of procedures on the ASC list, and it is beyond the scope of this rule to create payment groups that would provide payments closer to the costs of procedures that are either much more costly or much less costly than the existing highest and lowest ASC payment group.

In the November 26, 2004 ASC proposed rule, we proposed to delete 100 procedures from the ASC list, most of which were being performed in the office setting in more than half the number of cases. We also proposed to add 25 new procedures to the ASC list. Comments on the proposed rule indicate that the ASC cases for codes proposed for deletion from the ASC list will migrate to the outpatient hospital setting rather than to the physician office setting because the procedures performed in ASCs involve patients who need anesthesia, or who have significant comorbidities or anatomic abnormalities, or who require a sterile operating room.

Based in part on the convincing arguments and clinical evidence submitted by commenters, we are deleting only five procedures from the ASC list out of the original 100

procedures that we proposed to delete. We have noted minimal shifts among ambulatory sites of service over the past decade even though most of the codes that we proposed to delete have been on the ASC list throughout that period. In other words, the availability of these procedures in ASCs has not induced substantial shifts in the site of service. We are also adding 67 procedures to the ASC list, based on commenters' recommendations.

Over the past several years, the number of small, physician-owned specialty hospitals specializing in surgical and orthopedic services has grown rapidly. We have investigated this set of hospitals as part of our research in support of a report to the Congress mandated by section 507(c) of the MMA. Among other findings, we discovered that the surgical and orthopedic hospitals that billed the program in 2003 had an average daily census of 4.5. The predominant services in these hospitals appeared to be outpatient services rather than inpatient services. We speculate that physicians may be participating in the ownership of small hospitals rather than ASCs partly in order to take advantage of payment differences: under Medicare's current payment systems, outpatient services in many instances receive higher payments under the outpatient

prospective payment system than under the ASC fee schedule.

Section 626 of the MMA requires and sets parameters for a revision to the ASC fee schedule. The existing fee schedule is comparatively crude, with only nine payment rates used for approximately 2500 different surgical procedures. Consequently, each payment cell spans a broad set of clinically heterogeneous services. In addition, the basic structure of rates has not been updated since 1990. This combination of factors has resulted, among other things, in incentives to perform procedures in a hospital outpatient setting rather than an ASC, or the converse, when payment rates for particular procedures diverge significantly from the resources consumed in connection with the procedures. Reforming the ASC fee schedule can materially reduce these divergences and mitigate inappropriate incentives from this quarter that favor proliferation of specialty hospitals.

The MMA requires that the new payment system be implemented after December 2005 and not later than 2008. GAO has prepared and is about to conduct a survey to determine the relative costs associated with procedures performed in ASCs as part of a report to Congress required under the MMA. We are to take into account the

recommendations contained in the GAO report. Given the need to collect and analyze data and to complete full notice-and-comment rulemaking, we plan to implement the ASC payment reform January 1, 2008. Flowing from the MMA requirement that the GAO compare the relative costs of procedures furnished in ASCs to the relative costs of procedures furnished in hospital outpatient departments, we are exploring relating the ASC fee schedule to the outpatient prospective payment system, using the same or very similar ambulatory payment classifications. Linking the two systems could provide a mechanism for automatic updates of weights in the ASC system and reduce divergences between the two payments to an average percentage value.

B. Proposed Deletions

In accordance with the statutory requirement that we review and update the ASC list at least every 2 years, we, in consultation with our medical advisors, reviewed the current ASC list against the criteria. In this review, we also considered deletions recommended by medical specialty societies and other commenters. Further, we reviewed the codes that the OIG recommended for deletion from the ASC list. In most cases, our medical advisors agreed that the procedures recommended by the OIG for deletion no longer

met the criteria for ASC procedures, and we proposed to delete most of them from the ASC list. We removed the following seven procedures recommended for deletion by the OIG from the ASC list: CPT codes 21920, 42104, 51725, 56405, 56605, 62367, and 62368.

However, there were 11 procedures the OIG recommended for deletion that our medical advisors determined, for health and safety reasons, should be retained on the list:

Table 1. Procedures OIG Recommended for Deletion Not Proposed for Deletion

CPT code	Short Descriptor
30802	Cauterization, inner nose
31525	Diagnostic laryngoscopy
31570	Laryngoscopy with injection
45305	Proctosigmoidoscopy w/bx
46050	Incision of anal abscess
51710	Change of bladder tube
51726	Complex cystometrogram
51772	Urethra pressure profile
52285	Cystoscopy and treatment
67031	Laser surgery, eye strands
67921	Repair eyelid defect

We received no comments about this proposal, and we are making final our proposal to retain these procedures on the ASC list.

Based on our review of other procedures on the ASC list, we proposed to delete from the ASC list those listed in Table 2, for the reasons specified.

Rationale for deletion is indicated as follows:

1. Procedure is performed in physician's office more than 50 percent of the time.
2. Medical specialty organizations recommended deletion because of safety concerns.
3. Procedure is performed predominantly in the inpatient setting.
4. OIG recommended for deletion and CMS medical advisors concur.

Table 2. Proposed Deletions From the ASC List

CPT code	Short Descriptor	Rationale
11404	Removal of skin lesion	4
11424	Removal of skin lesion	4
11444	Removal of skin lesion	4
11446	Removal of skin lesion	4
11604	Removal of skin lesion	4
11624	Removal of skin lesion	4
11644	Removal of skin lesion	4
12021	Closure of split wound	4
13100	Repair of wound or lesion	4
13101	Repair of wound or lesion	4
13120	Repair of wound or lesion	4
13121	Repair of wound or lesion	4
13131	Repair of wound or lesion	4

13132	Repair of wound or lesion	4
13150	Repair of wound or lesion	4
13151	Repair of wound or lesion	4
13152	Repair of wound or lesion	4
14000	Skin tissue rearrangement	4
14020	Skin tissue rearrangement	4
14021	Skin tissue rearrangement	4
14040	Skin tissue rearrangement	4
14041	Skin tissue rearrangement	4
14060	Skin tissue rearrangement	4
14061	Skin tissue rearrangement	4
15732	Muscle-skin graft, head/neck	2
15734	Muscle-skin graft, trunk	2
15738	Muscle-skin graft, leg	2
15740	Island pedicle flap graft	4
19100	Bx breast percut w/o image	4
20670	Removal of support implant	4
21040	Removal of jaw bone lesion	1
21050	Removal of jaw joint	2
21206	Reconstruct upper jaw bone	1
21210	Face bone graft	1
21249	Reconstruction of jaw	1
21325	Treatment of nose fracture	1
21355	Treat cheek bone fracture	1
21440	Treat dental ridge fracture	1
21485	Reset dislocated jaw	1
22305	Treat spine process fracture	4
23600	Treat humerus fracture	4
23620	Treat humerus fracture	4
24576	Treat humerus fracture	1
24670	Treat ulnar fracture	4
25505	Treat fracture of radius	1
26605	Treat metacarpal fracture	4
27520	Treat kneecap fracture	4
27760	Treatment of ankle fracture	4

27780	Treatment of fibula fracture	4
27786	Treatment of ankle fracture	4
27808	Treatment of ankle fracture	4
28400	Treatment of heel fracture	4
30801	Cauterization, inner nose	4
30915	Ligation, nasal sinus artery	2
30920	Ligation, upper jaw artery	2
31233	Nasal/sinus endoscopy, dx	4
31235	Nasal/sinus endoscopy, dx	4
31237	Nasal/sinus endoscopy, surg	4
31238	Nasal/sinus endoscopy, surg	4
38505	Needle biopsy, lymph nodes	4
40700	Repair cleft lip/nasal	2
40701	Repair cleft lip/nasal	2
40814	Excise/repair mouth lesion	4
41009	Drainage of mouth lesion	1
41010	Incision of tongue fold	1
41112	Excision of tongue lesion	4
41520	Reconstruction, tongue fold	1
41800	Drainage of gum lesion	1
41827	Excision of gum lesion	1
42000	Drainage mouth roof lesion	1
42107	Excision lesion, mouth roof	1
42200	Reconstruct cleft palate	2
42205	Reconstruct cleft palate	2
42210	Reconstruct cleft palate	2
42215	Reconstruct cleft palate	2
42220	Reconstruct cleft palate	2
42409	Drainage of salivary cyst	1
42425	Excise parotid gland/lesion	3
42860	Excision of tonsil tags	1
42892	Revision pharyngeal walls	3
52000	Cystoscopy	4
52281	Cystoscopy and treatment	4
53850	Prostatic microwave thermotx	1

55700	Biopsy of prostate	4
58820	Drain ovary abscess, open	3
60000	Drain thyroid/tongue cyst	1
64420	N block inj, intercost, sng	4
64430	N block inj, pudendal	1
64736	Incision of chin nerve	1
65800	Drainage of eye	1
65805	Drainage of eye	4
67141	Treatment of retina	4
68340	Separate eyelid adhesions	1
68810	Probe nasolacrimal duct	4
69145	Remove ear canal lesion(s)	4
69450	Eardrum revision	2
69725	Release facial nerve	1
69740	Repair facial nerve	2
69745	Repair facial nerve	2
69840	Revise inner ear window	1

As displayed in Table 2, among the codes we proposed to delete from the ASC list were CPT codes 52000, Cystourethroscopy, 52281, Cystourethroscopy, with calibration and /dilation of urethral stricture or stenosis, with or without meatotomy, with or without injection procedure for cystography, and 55700, Biopsy, prostate; needle or punch, single or multiple, any approach. We proposed deletion of these codes from the list in response to the recommendations of the OIG. The study recommended that Medicare be a prudent purchaser of services and only pay for those that are necessary for the

efficient delivery of needed health services. The OIG found that discrepancies in the payment amounts between services furnished in the ASC and in the hospital outpatient setting resulted in additional and unnecessary program payments. The OIG also asserted that retention of these codes was inconsistent with our criteria for procedures that are appropriately performed in an ASC. Based on their study findings, the OIG recommended that procedures be removed from the ASC list with the expectation that those deleted services would then be furnished in the physician office setting at a lower cost to Medicare.

These procedures have been on the list of Medicare-approved ASC procedures since its inception. However, in our review of the procedures on the ASC list for the biennial update, we found that the codes did not satisfy our criteria for inclusion on the list and, in addition, the OIG's report recommendation made it clear that we should propose removal of the procedures.

Comment: We received several hundred comments from the public opposing the deletion of these three codes. The commenters provided a number of arguments for retaining the codes on the ASC list. They asserted that there are

circumstances when clinically compelling reasons require that these procedures be performed in a facility setting rather than in the physician office. Examples of those circumstances include the need for general anesthesia and the need for access to more highly qualified staff and a full spectrum of emergency equipment for patients with various comorbidities. Many Medicare beneficiaries have diabetes, prior myocardial infarctions, renal insufficiency or urological malignancies, any of which may indicate performance of the procedure in a facility setting.

The commenters also questioned our estimated cost savings as a result of the deletions. They stated that the procedures would not shift from the ASC to the physician office as assumed by the OIG, but would instead shift to the hospital outpatient department in most cases. Further, they asserted that deletion of the codes from the ASC list will impose a barrier to access for those beneficiaries with limited access to a hospital outpatient facility. They asserted that the deletion of these codes would actually result in additional costs for the Medicare program.

Response: We have considered the comments and conclude that CPT codes 52000, 52281, and 55700 should be

retained on the ASC list. We find the clinical arguments contained in the comments to be compelling, and we believe that protecting patient safety and access to appropriate care is our primary responsibility.

We examined Medicare site of service data for the past 10 years and found that the pattern for the site of service for the procedures generally was stable. Consistently, the physician office is the predominant service setting even though the procedures were included on the ASC list. As exhibited in Table 3 below, in 1992, 70 percent of cystourethroscopies (52000) were furnished in the physician office, 17.5 percent in the outpatient department and 3.3 percent in the ASC. The change in distribution across sites of service for this procedure from 1992 through 2003 is minimal. Generally, the data show a trend of decreasing volume in the hospital outpatient department accompanied by an increased volume in the physician office. With the exception of CY 2000, volume in the ASC setting has remained significantly less than 10 percent of the total cases.

Table 3. Site of Service for Cystourethroscopies (CPT 52000), 1992 - 2003

Year	OFFICE	%(TOTAL)	OPD	%(TOTAL)	ASC	%(TOTAL)	TOTAL
1992	563,548	70.0%	140,805	17.5%	26,369	3.3%	804,683
1995	581,672	72.1%	133,024	16.5%	41,990	5.2%	807,302
2000	618,984	74.1%	102,109	12.2%	79,116	9.5%	835,669
2003	725,000	80.1%	92,981	10.3%	55,543	6.1%	904,860

We found similar patterns in the Medicare site of service data for the other two high volume urology procedures, CPT codes 52281 and 55700, that we proposed to delete. We believe that the relative stability of the utilization and site of service is evidence that the inclusion of the codes on the ASC list has not influenced the physician’s selection of setting for performance of the procedures and provides strong evidence that there is a small but consistent population of beneficiaries for whom the ASC setting is the most appropriate for these procedures.

In light of the evidence presented to us in the comments, we agree with commenters that these procedures should be retained on the ASC list in spite of the high

percentage of cases performed in the physician office setting. Moreover, in light of our plans to develop and implement a new payment system for ASCs by 2008 and our expectation that the criteria for inclusion on the ASC list will be reviewed as part of developing the new payment system, we believe that deleting these codes at this time could cause undue confusion and hardship for many beneficiaries.

If we accept the commenters' assertions that many of the procedures currently furnished in the ASC must be performed in a facility setting, as we have, we must reconsider the cost savings estimates that we assumed when we proposed deletion of these codes. If a significant portion of the procedures will migrate to the hospital outpatient department rather than to the physician office, then we may have diminished cost saving estimates compared to those included in our proposed rule, with resultant increased payment by the Medicare program rather than savings. See section IV of this interim final rule for a full discussion of cost savings estimates.

Comment: In addition to the comments requesting that we not delete the three procedures, CPT codes 52000, 52281, and 55700, we received about 100 comments requesting that

we not delete CPT codes 11404 through 15740, as listed in Table 2. These commenters made many of the same points discussed above regarding deletion of this range of procedure codes. The same concerns regarding patient safety and access to appropriate care were consistently raised.

The commenters presented equally compelling clinical arguments opposing deletion of these procedures. They assert that it is often difficult to schedule these non-emergent procedures in outpatient departments but that the need for sterile conditions for the procedures requires a facility setting rather than the physician office. Many patients require heavy sedation or general anesthesia because of the delicate nature of many of the procedures, and need a facility setting due to Medicare patient comorbidities. Further, commenters cited a number of CPT coding definitions that make it impossible to identify important information about specific procedures that are performed. That is, one code describes a number of different procedures, some of which are significantly more complex than others reported using the same CPT code. For example, CPT code 31233, Nasal/sinus endoscopy, diagnostic with maxillary sinusoscopy (via inferior meatus or canine

fossa puncture), describes a procedure that may be accomplished by either of two distinct approaches, one of which may require no anesthesia while the other (requiring insertion of a trochar through the roof of the patient's mouth) does require sedation in a facility setting.

Further, they assert that the deletion of the codes as proposed will not result in cost savings for the Medicare program but will result in diminished beneficiary access to appropriate care and to cost increases because the cases currently performed in the ASC will shift to hospital outpatient departments.

Response: We find the commenters' arguments convincing. We examined the site of service for these procedures over the past 5 years, and, as was the case for the urology codes, we found that the patterns for provision of these services were generally unchanged during that time. In light of the clinical evidence presented in the comments and our finding that the percent of procedures that are being performed in the ASC today is no greater than it was in 1999, we conclude that these procedures should be retained on the ASC list, and we will not make final our proposal to delete them.

Further, we believe that the estimated cost savings included in the proposed rule may have been over-stated. Therefore, we performed cost analyses using predicted site of service distribution changes that we believe are more realistic than those we used in the proposed rule. A full discussion of the cost estimates is presented in section V of this rule.

Comment: We received comments opposing the deletion of almost every procedure we proposed to delete in the proposed rule. The reasons provided were generally the same as those presented by the commenters regarding the urology and skin codes discussed above: that there is a portion of the Medicare patient population who, due to clinical characteristics or due to limitations on access, is best served by having access to these procedures in an ASC.

Response: We have examined the comments, the site of service data, and the list of proposed deletions, and we have decided that the evidence supplied by the commenters regarding the three urology procedures and the skin procedures, combined with the impending implementation of a new payment system in 2008 argue against making major changes in the ASC list at this time. Maintaining a degree

of stability in the ASC list until the new payment system is implemented will minimize the risk of limiting beneficiary access to needed services as well as unintended incentives that could result in significant shifts of procedures to the generally more costly hospital outpatient setting.

Therefore, we will delete only the five codes about which we received no comments. CPT codes 21440, 23600, and 23620 are all procedures that are performed in the office setting more than half of the time. CPT code 69725 is performed as an inpatient procedure 100 percent of the time. The resources required to perform CPT code 53850 significantly exceed the highest ASC payment group. Therefore, we are making final our proposal to delete the five codes listed in Table 4.

Table 4. Final List of Codes Deleted From the ASC List

CPT Code	Descriptor
21440	Treat dental ridge fracture
23600	Treat humerus fracture
23620	Treat humerus fracture
53850	Prostatic microwave thermotx
69725	Release facial nerve

C. Proposed Additions

1. Additions Recommended by Commenters and Other Interested Parties

In response to public comments and our medical staff review, we proposed to add the procedures displayed in Table 5 to the list of Medicare-approved ASC procedures.

Table 5. Proposed Additions Recommended by Commenters and Other Interested Parties

HCPCS Code	Short Descriptor	Proposed Payment Group
15001	Skin graft add-on	1
15836	Excise excessive skin tissue	3
15839	Excise excessive skin tissue	3
21120	Reconstruction of chin	7
21125	Augmentation, lower jaw bone	7
29873	Knee arthroscopy/surgery	3
30220	Insert nasal septal button	3
31500	Insert emergency airway	1
31603	Incision of windpipe	1
35475	Repair arterial blockage	9
35476	Repair venous blockage	9
36834	Repair AV aneurysm	3
37205	Transcatheter stent	9
37206	Transcatheter stent add-on	9
37500	Endoscopy ligate perf veins	3
42665	Ligation of salivary duct	7
44397	Colonoscopy w/stent	1
45327	Proctosigmoidoscopy w/stent	1
45341	Sigmoidoscopy w/ultrasound	1
45342	Sigmoidoscopy w/us guide bx	1
45345	Sigmoidoscopy w/stent	1
45387	Colonoscopy w/stent	1

57288	Repair bladder defect	5
62264	Epidural lysis on single day	1
67343	Release eye tissue	7

Comment: We received many comments in support of the proposed additions to the ASC list. However, we received one comment that opposed the additions of CPT codes 37205, 37206, 35475, and 35476. The commenter stated that these procedures were not appropriate for the ASC setting and would allow for potential substandard care.

Response: Our medical staff's reconsideration of these procedures led to our decision not to add them to the ASC list. The procedures involve major vessels and therefore do not meet our criteria for inclusion on the ASC list.

CPT code 31500, Insert emergency airway, also will be removed from the list of additions to be made final. We will not add this procedure to the ASC list because it would be significantly overpaid even in the lowest ASC payment group. As discussed in our March 2003, final rule (68 FR 15270), our policy is not to add procedures for which significant overpayments would result.

However, we will make final our proposal to add the other codes in Table 5. The final list of all procedures to be added to the ASC list is in section II, Table 7.

Comment: We also received a number of comments requesting higher payment levels than those proposed for some of the codes. Table 6 provides a summary display of the procedure codes and the proposed payment group assignments and the commenter-requested payment group assignments for the codes for which a specific group was identified. For several procedures, there was variation among commenters regarding payment group requests and so more than one payment group is identified.

Table 6. Payment Group Assignments Proposed and As Requested by Commenters

HCPCS Code	Short Descriptor	NPRM Payment group	Requested Payment Group
15836	Excise excessive skin tissue	3	5
15839	Excise excessive skin tissue	3	5
29873	Knee arthroscopy/surgery	3	4
37500	Endoscopy ligate perf veins	3	N/A
44397	Colonoscopy w/stent	1	3
45327	Proctosigmoidoscopy w/stent	1	3
45341	Sigmoidoscopy w/ultrasound	1	2,3 & 9
45342	Sigmoidoscopy w/us guide bx	1	2,3 & 9
45345	Sigmoidoscopy w/stent	1	2,3 & 9
45387	Colonoscopy w/stent	1	3
57288	Repair bladder defect	1	9

62264	Epidural lysis on single day	1	N/A

Response: We considered each of these requests and believe that the payment groups that we proposed are appropriate. In making the proposed assignments, we considered the assignments of codes already on the ASC list that the proposed additions most closely resembled in terms of clinical work and resource inputs such as equipment, supplies, and time required in the operating suite. To the extent possible, we assigned the additions to the list to the same payment groups to which comparable procedures are currently assigned. We will make no changes at this time and will make final the payment groups as proposed.

D. Procedures Requested for Addition in Comments

We also received a large number of comments requesting that we add procedures to the ASC list in addition to those we proposed to add in the November 26, 2004 proposed rule. Following is a discussion of each of those requests.

Comment: We received a comment requesting that we add CPT codes 10061, Incision and drainage of abscess, complicated or multiple, and 10081, Incision and drainage of pilonidal cyst, complicated, to the Medicare list of procedures covered in the ASC.

Response: We reviewed the site of service data for these procedures and discussed the request with our medical staff. CPT codes 10061 and 10081 are performed most of the time in the physician office, and we believe that they are most appropriately performed there and do not believe that they are procedures that should be added to the ASC list.

Comment: Several commenters requested that we add CPT code 61795 (stereotactic computer assisted volumetric (navigational) procedure). The commenters stated that this procedure is reported with other procedures on the list and is already reimbursed by most commercial payors in most settings, including ASCs. They stated that Medicare also reimburses this technology in both the inpatient and outpatient setting and that it is appropriate for an ASC.

Response: CPT code 61795 is for coding the use of equipment, is not a surgical procedure, and is therefore, not an appropriate addition to the ASC list. We will not add this to the ASC list of covered procedures.

Comment: Many commenters requested that we add CPT code 30220 (insertion, nasal septal prosthesis) to the ASC list. They stated that it was clinically appropriate for the ASC setting.

Response: This procedure meets our criteria for inclusion on the ASC list. We agree that it is appropriate for the ASC list and are adding this procedure to payment group 3.

Comment: We received a request to add CPT code 31040 (pterygomaxillary fossa surgery). The commenters stated that it is clinically similar to CPT code 30920, Ligation arteries: internal maxillary artery transantral, a procedure already on the list and meets our criteria for inclusion on the ASC list.

Response: Our medical staff do not agree that these two codes are comparable. CPT code 30920 is furnished as an inpatient procedure 61 percent of the time and was proposed for deletion from the list in the November 26, 2004 proposed rule. CPT code 31040 is predominantly an office procedure (66 percent of the time). We do not believe that CPT code 31040 is an appropriate addition to the ASC list at this time.

Comment: Many commenters requested that we add CPT code 31545 (Laryngoscopy, direct, operative, w/operating microscope or telescope, w/submucosal removal of non-neoplastic lesion of vocal cord, reconstruction local tissue flap); and CPT code 31546 (Laryngoscopy, direct,

operative, w/operating microscope or telescope, w/ submucosal removal of non-neoplastic lesion of vocal cord, reconstruction with graft (incl. obtaining autograft)). They stated that these procedures are clinically similar to the procedures in the CPT codes 31615 through 31656 range, many of which are currently on the list.

Response: Our medical staff agrees that CPT codes 31545 and 31546 are clinically similar to some endoscopic lesion removal and skin flap or grafting procedures that are already on the list. We are adding both of these procedures to the ASC list in payment group 4.

Comment: We received a few requests to add CPT code 40812 (Excision of lesion of mucosa and submucosa, vestibule of mouth; with simple repair).

Response: We are not adding the procedure to the ASC list. This is primarily an office procedure. Data show that the procedure does not meet our criteria for office volume percentage and does not typically require the resources of a facility setting. For the small percentage of times that a facility setting is warranted, the procedure could be furnished in the hospital outpatient department.

Comment: A few commenters requested that we add CPT codes 42842 (Radical resection, tonsil, tonsillar pillars, &/or retromolar trigone; w/o closure); and 42844 (Radical resection, tonsil, tonsillar pillars, &/or retromolar trigone; closure w/loca). The commenters stated that these procedures meet our criteria and are appropriate for an ASC.

Response: Clinically, these procedures typically require the resources of the hospital inpatient setting. While these procedures are also performed on an outpatient basis, the risks of complication require the ability to initiate an immediate inpatient response making these procedures inappropriate in the ASC setting.

Comment: We received several comments requesting that we add CPT code 43761, Repositioning of the gastric feeding tube, any method, through the duodenum for enteric nutrition, to the Medicare ASC list. The commenters believe that the addition is warranted in order to provide more latitude to physicians and patients to choose the site of service for performance of this procedure.

Response: This procedure is most often performed in the inpatient hospital setting, and our medical staff do

not believe that CPT code 43761 is an appropriate procedure for the ASC setting.

Comment: Several commenters requested that the following eight CPT codes be added to the Medicare ASC list.

- 45300 Proctosigmoidoscopy, rigid; diagnostic, with or without collection of specimen(s) by brushing or washing
- 45303 Proctosigmoidoscopy, rigid; diagnostic, with dilation (for example, balloon, guide wire, bougie)
- 45330 Sigmoidoscopy, flexible; diagnostic, with or without collection of specimen(s) by brushing or washing
- 46604 Anoscopy, diagnostic, with or without collection of specimen(s) by brushing or washing, with dilation (for example, balloon, guide wire, bougie)
- 46614 Anoscopy, diagnostic, with or without collection of specimen(s) by brushing or washing, with control bleeding (for example, injection, bipolar cautery, unipolar cautery, laser, heater probe)
- 46900 Destruction of lesion(s), anus, simple; chemical

- 46910 Destruction of lesion(s), anus, simple; electrodesication
- 46916 Destruction of lesion(s), anus, simple; cryosurgery

The commenter believes the codes should be added to the ASC list to afford more latitude to patients and physicians with regard to choice of site of service. They point out that although these procedures are usually performed in the physician office, there are circumstances under which a facility environment that is sterile and in which administration of general anesthesia is safe, is required. They believe that the ASC should be one of the options available.

Response: With the exception of CPT code 45303, all of these procedures are performed in the physician office more that half of the time, and we do not believe that adding them to the ASC list is appropriate.

Comment: We received a number of comments requesting that we add CPT codes 47562, Laparoscopic cholecystectomy; 47563, Laparoscopic cholecystectomy with cholangiography; and 47564, Laparoscopic cholecystectomy with exploration of the common bile duct. The commenters believe that these

procedures qualify for performance in the ASC setting because the procedures usually take less than 60 minutes and the recovery time is usually less than 2 hours. The commenters say that laparoscopic cholecystectomies are substantially similar to laparoscopic cholangiography (CPT codes 47561 and 47562), that are on the ASC procedure list.

Response: After consultation with our medical staff, we decided that laparoscopic cholecystectomies are not appropriate for addition to the Medicare list of procedures for performance in an ASC. There is a substantial risk that the laparoscopic approach will not be successful and that an open procedure will have to be performed instead. If an open procedure is required, the patient will have to be transported to a hospital for the procedure and subsequent hospital admission. The potential jeopardy to the beneficiary resulting from undergoing an emergency transfer is significant and far outweighs any benefit of covering these procedures in ASCs. For this reason we believe that laparoscopic cholecystectomies should continue to be performed in a hospital setting (either inpatient or outpatient) as is the current practice.

Comment: We received several comments requesting that we add CPT codes 46221, Hemorrhoidectomy, by simple

ligature; 46946, Ligation of internal hemorrhoids, multiple procedures; and 46947, Hemorrhoidopexy by stapling, to the Medicare list of ASC procedures. The commenters stated that these procedures are commonly performed on non-Medicare beneficiaries in the ASC setting. Further, they write that, although the procedures often are performed in the physician office setting, there are circumstances under which a facility setting is warranted. For example, for patients with certain comorbidities, it may be best to perform the surgery in a setting where anesthesia can be safely administered and emergency response capabilities are available and so should be performed in a facility. The physician and patient should have more latitude to make site of service determinations.

Response: The most common site of service for hemorrhoidectomy by simple ligature (CPT code 46221) and ligation of internal hemorrhoids (CPT code 46946) is the physician office, and we do not believe that there is a clinical basis for adding either of these codes to the ASC list. Hemorrhoidopexy by stapling is a new procedure for 2005, and our medical staff believe that the procedure is of a complexity substantially similar to other procedures (for example, CPT code 46257, hemorrhoidectomy, internal

and external, with fissurectomy) assigned to payment group 3, and so we will add CPT code 46947 to the ASC list and will assign it to payment group 3.

Comment: We received a comment requesting that we add CPT codes 45391, Colonoscopy with endoscopic ultrasound guidance; and 45392, Colonoscopy with transendoscopic US guided intramural or transmural fine needle aspiration/biopsy, to the ASC list. These are new codes for 2005, and the commenter believes that the procedures are appropriate for performance in the ASC setting.

Response: Colonoscopy CPT codes 45378 through 45387 are included on the list for ASCs. We believe that the new codes are comparable to the colonoscopy procedures currently included on the list, and so we will add CPT codes 45391 and 45392 as well. We will assign these two codes to payment group 2.

Comment: We received a comment requesting that we add CPT code 46230, Excision of external hemorrhoid tags and/or multiple papillae, to the ASC list. The commenter believes that this code is appropriate for the ASC list because its performance is consistent with the criteria we have set for inclusion on the ASC list.

Response: Examination of the site of service data reveals that this procedure is performed 48 percent of the time in the physician office and 41 percent of the time in the outpatient department. We believe that it is comparable to CPT code 46220, Papillectomy or excision of single tag, anus, which is included in the ASC list. We agree with the commenter that this is an appropriate addition to the list. Therefore, we will add it and assign it to group 1.

Comment: One commenter requested that we add CPT code 46706, Repair of anal fistula with fibrin glue, to the list because the aspects associated with performance of the procedure are consistent with the criteria for inclusion of the procedure on the ASC list.

Response: The site of service data for this procedure show that it is performed 86 percent of the time in the outpatient department and only 1 percent of the time in the physician office setting. We agree with the commenter that this procedure is appropriate for addition to the ASC list. We will add the procedure and will assign it to payment group 1.

Comment: One commenter requested that we add CPT code 49419, Insertion of intraperitoneal cannula or catheter,

with subcutaneous reservoir, permanent, to the ASC list. The commenter stated that since CPT codes 49420, Insertion of intraperitoneal cannula or catheter for drainage or dialysis; temporary, 49421, Insertion of intraperitoneal cannula or catheter for drainage or dialysis; permanent, and 49422, Removal of permanent intraperitoneal cannula or catheter, are on the ASC list, CPT code 49419 should also be included.

Response: We agree with the commenter that CPT code 49419 should also be added to the ASC list. We will add it to the list in payment group 1 with CPT codes 49420, 49421 and 49422.

Comment: Several commenters requested that we add CPT code 52301, Cystourethroscopy; with resection or fulguration of ectopic ureterocele(s), unilateral or bilateral, to the ASC list. They stated that, due to patient discomfort, the procedure should be offered in the ASC where general anesthesia can be administered. They also noted that the procedure meets the ASC list criteria since it takes only 60 minutes of intra-operative time, 45 to 60 minutes of recovery time, involves only minimal blood loss and is similar to at least one other procedure that is on the ASC list, CPT code 52214, Cystourethroscopy, with

ejaculatory duct catheterization, with or without irrigation, instillation or duct radiography, exclusive of radiologic service.

Response: We agree with the commenter that this procedure is very similar to other cystoscopic procedures on the ASC list and that it be added to the list. We will add it to the list and assign it to payment group 3.

Comment: We received a comment requesting that we add CPT code 52402, Cystourethroscopy with transurethral resection or incision of ejaculatory ducts, to the ASC list.

Response: This is a new code for 2005 but we believe that it is similar enough to other existing procedures that we can make a decision about adding it to the list. Our medical staff believes that it is an appropriate procedure for inclusion on the list, and we will add it and assign it to payment group 3.

Comment: We received a few comments requesting that we add CPT code 57287, Removal or revision of sling for stress incontinence, to the ASC list.

Response: This is an open surgical procedure and our medical staff believes that more than 4 hours are needed

for recovery time. Therefore, we do not believe that this is an appropriate addition to the ASC list.

Comment: We received a comment requesting that we add CPT code 51992, Laparoscopy, surgical; sling operation for stress incontinence, to the ASC list. The commenter believes that it meets our criteria for addition.

Response: This procedure is performed most of the time in the hospital setting, either inpatient or outpatient, and our medical staff believe that it is an appropriate procedure for inclusion on the ASC list. We will add it to the ASC list and assign it to payment group 5.

Comment: We received comments requesting that we add CPT codes 64517, Injection, anesthetic agent; superior hypogastric plexus; and 64681, Destruction by neurolytic agent, with or without radiologic monitoring; superior hypogastric plexus, to the ASC list. The commenter stated that these CPT codes were established in 2004 to add more specificity to the coding and that before that they were included on the ASC list under CPT code 64520, Injection, anesthetic agent; lumbar or thoracic (paravertebral sympathetic). The commenter stated that CPT codes 64517

and 64681 should be included on the list as is CPT code 64520.

Response: We do not have site of service data for these two procedures but agree with the commenter that they are similar to CPT code 64520 for which site of service data indicate that it is appropriately included on the ASC list. Therefore, we will add both of these codes to the list and will assign them to payment group 2.

Comment: We received several comments requesting that we add CPT codes 62290, Injection procedure for discography, lumbar, and 62291, Injection procedure for discography, cervical or thoracic, to the Medicare ASC list. The commenters state that CPT codes 62290 and 62291 are similar to CPT codes 62287, Aspiration or decompression procedure, percutaneous, of nucleus pulposus of intervertebral disk; and 62294, Injection procedure, arterial, for occlusion of arteriovenous malformation, which are included on the ASC list. The commenters wrote that in both procedures the physician places a needle into the intervertebral disk while the patient is under conscious sedation. The procedures typically involve X-ray to guide the needle placement, and most physician offices are not equipped for these services. Although most

Medicare patients (about 65 percent) go to the outpatient hospital setting for the procedures, most non-Medicare patients are able to have the procedures in ASCs. They believe that Medicare beneficiaries should have the same treatment options.

Response: We consider the procedures coded 62290 and 62291 to be integral to radiologic studies and are never performed alone and, as such, are not appropriate for addition to the ASC list. Radiologic studies that do not include an intervention are not considered surgical procedures and are not included on the list of ASC procedures. The procedures that are currently included on the ASC list that the commenters have chosen for comparison, CPT codes 62287 and 62294, are interventional procedures and are, therefore, not valid comparatives for this purpose.

Comment: Several commenters requested that CPT codes 62367, Electronic analysis of programmable implanted pump for intrathecal or epidural drug infusion, without reprogramming; and 62368, Electronic analysis of programmable implanted pump for intrathecal or epidural drug infusion, with reprogramming, be added to the ASC list. They stated that because the procedures require

X-ray imaging and because most physician offices are not adequately equipped for the services, Medicare beneficiaries typically go to the hospital for these services. They believe that Medicare beneficiaries should have the same site of service options as does the non-Medicare population.

Response: Our data show that more than 75 percent of these services are provided to Medicare beneficiaries in the office setting. We believe that this is appropriate. These are not surgical procedures and are not of a level of complexity to warrant addition to the ASC list.

Comment: We received one comment requesting that CPT codes 64561, Percutaneous implantation of neurostimulator electrodes, sacral nerve; 64581, Incision for implant of neurostimulator electrodes, sacral nerve; and 95972, Intra-operative programming of implanted neurostimulator, be added to the ASC list. The commenter stated that these codes should be included because CPT code 64590, Insertion or replacement of peripheral neurostimulator pulse generator or receiver, direct or inductive coupling, is on the list.

Response: We agree with the commenter that CPT codes 64561 and 64581 are appropriate additions to the ASC list.

We will add them to the list and assign them to payment group 3. We do not agree that CPT code 95972 is an appropriate addition because it is an analysis of the implanted device and is not a surgical procedure, and therefore, does not meet the criteria for the ASC list of procedures.

Comment: A number of commenters requested that we add CPT code 31040, Pterygomaxillary fossa surgery, to the ASC list. They believe that the procedure is similar to CPT code 30920, Ligation internal maxillary artery, transantral, which is included on the list, and that beneficiaries and their physicians should have ASCs as an option for site of service.

Response: According to our data, the site of service for these two procedures is very different. Pterygomaxillary fossa surgery is performed in the physician office 66 percent of the time and on an inpatient basis 19 percent of the time compared to only 2 percent in the physician office and 61 percent in the inpatient setting for ligation of internal maxillary artery, transantral. We will not add CPT code 31040 to the list at this time because it is primarily an office-based procedure.

Comment: We received several comments requesting that we add CPT Level II code G0289, Arthroscopy, knee, surgical, for removal of loose body, foreign body, debridement/shaving or articular cartilage (chondroplasty) at the time of other surgical knee arthroscopy in a different compartment of the same knee, to the ASC list of procedures. The commenters believe that the additional time (at least 15 minutes) represented by this code should be recognized for payment in the ASC setting.

Response: By definition, the procedure represented by CPT Level II code G0289 is part of another procedure and is never furnished as a separate procedure. For this reason, we will not add it to the ASC list.

Comment: We received a number of comments requesting the addition of CPT codes 21030, Excision of benign tumor or cyst of maxilla or zygoma by enucleation and curettage; 21031, Excision of torus mandibularis; and 21032, Excision of maxillary torus palatinus, to the ASC list. The commenters stated that although these procedures are often furnished in the physician office, occasionally a facility setting is required for a patient who requires a deeper level of anesthesia or monitoring or whose condition warrants a sterile environment.

Response: Our data indicate that these services are furnished in the physician office more than 80 percent of the time, and therefore we will not add these to the list at this time.

Comment: We received a number of comments requesting that we add CPT codes 22520, Percutaneous vertebroplasty, one vertebral body, uni- or bi-lateral injection; thoracic; 22521, Percutaneous vertebroplasty, one vertebral body, uni- or bi-lateral injection; lumbar; and 22522, Percutaneous vertebroplasty, one vertebral body, uni- or bi-lateral injection; each additional thoracic or lumbar vertebral body, to the ASC list. The commenters stated that the procedures require about one hour per vertebra, that the recovery time also is about 1 hour and that the procedures can be safely furnished in the ASC.

Response: Our medical staff reviewed these procedures and determined that there is often an overnight stay required for patients who undergo vertebroplasty procedures. We believe that the recovery period usually is longer than 4 hours and so will not add these to the list of ASC procedures at this time.

Comment We received several comments requesting that CPT code 27096, Injection procedure for sacroiliac joint,

arthrography and /or anesthetic steroid, be added to the Medicare ASC list. The commenters stated that the procedure is typically required to ensure proper placement of the needle into the sacroiliac joint and that most physician offices do not have the appropriate equipment for this, forcing Medicare beneficiaries to go to hospital outpatient departments, whereas non-Medicare patients may go to ASCs for this service.

Response: This is a radiological service that is furnished in the physician office setting more than half the time. We do not believe that it is an appropriate addition to the ASC list.

Comment: A number of commenters requested that we add CPT codes 27412, Autologous chondrocyte implantation, knee; and 27415, Osteochondral allograft, knee, open, to the ASC list because these new procedure codes meet our clinical procedure criteria for addition.

Response: The CPT codes 27412 and 27415 are new in 2005, and we have no site of service data on which to base our decision. However, our medical staff believes that these are still predominantly inpatient procedures and should not be added to the ASC list at this time. Therefore, we will not add these to the ASC list.

Comment: Several commenters asked that we add new CPT codes 29866, Arthroscopy, knee, surgical; osteochondral autograft(s); 29867, Arthroscopy, knee, surgical; osteochondral allograft; and 29868, Arthroscopy, knee, surgical; meniscal transplantation (includes arthrotomy for meniscal insertion), to the Medicare ASC list. The commenters stated that these procedures meet our clinical criteria for inclusion on the list and that they are similar to other knee arthroscopy procedures that currently are included on the list.

Response: The CPT codes 29866, 29867, 29868 are new in 2005, and, therefore, we have no site of service data on which to base our decisions. Our medical staff believes that the procedures are most often performed in the inpatient setting, however, and as such are not appropriate for addition to the ASC list. Therefore, we will not add these procedures to the ASC list.

Comment: We received one comment requesting that we add a number of CPT codes to the ASC list. For one of the codes, CPT code 63030, we received several requests for addition to the list. The requested additions are as follows:

CPT Code	Descriptor	Percent inpatient
63001	Laminectomy with exploration &/or decompression of spinal cord &/or cauda equina, w/o facetectomy, foraminotomy, or diskectomy, 1 or 2 vertebral segments; cervical	97
63003	Laminectomy with exploration &/or decompression of spinal cord &/or cauda equina, w/o facetectomy, foraminotomy or diskectomy, 1 or 2 vertebral segments; thoracic	98
63005	Laminectomy with exploration &/or decompression of spinal cord &/or cauda equina, w/o facetectomy, foraminotomy, or diskectomy, 1 or 2 vertebral segments; lumbar , except for spondylolisthesis	95
63011	Laminectomy with exploration &/or decompression of spinal cord &/or cauda equina, w/o facetectomy, foraminotomy, or diskectomy, 1 or 2 vertebral segments; sacral	98
63020	Laminotomy, (hemilaminectomy), w/decompression of nerve root(s), incl partial factectomy, foraminotomy &/or excision of herniated intervertebral disk; one interspace, cervical	88
63030	Laminotomy, (hemilaminectomy), w/decompression of nerve root(s), incl partial factectomy, foraminotomy &/or excision of herniated intervertebral disk; one interspace, lumbar (incl. Open or endoscopically-assisted approach)	84
63035	Laminotomy, (hemilaminectomy), w/decompression of nerve root(s), incl partial factectomy, foraminotomy &/or excision of herniated intervertebral disk; each additional interspace, cervical or lumbar	93
63040	Laminotomy, (hemilaminectomy), w/decompression of nerve root(s), incl partial factectomy, foraminotomy &/or excision of herniated intervertebral disk; reexploration, single interspace, cervical	94

63042	Laminotomy, (hemilaminectomy), w/decompression of nerve root(s), incl partial factectomy, foraminotomy &/or excision of herniated intervertebral disk; reexploration, single interspace, lumbar	93
63045	Laminotomy, (hemilaminectomy), factectomy and foraminotomy (uni- or bi-lateral w/decompression of spinal cord, cauda equina &/or nerve root(s)), single vertebral segment, cervical	96
63046	Laminotomy, (hemilaminectomy), factectomy and foraminotomy (uni- or bi-lateral w/decompression of spinal cord, cauda equina &/or nerve root(s)), single vertebral segment, thoracic	97
63047	Laminotomy, (hemilaminectomy), factectomy and foraminotomy (uni- or bi-lateral w/decompression of spinal cord, cauda equina &/or nerve root(s)), single vertebral segment, lumbar	94
63048	Laminotomy, (hemilaminectomy), factectomy and foraminotomy (uni- or bi-lateral w/decompression of spinal cord, cauda equina &/or nerve root(s)), single vertebral segment, each additional segment, cervical, thoracic or lumbar	96

The commenter asserted that, although these are usually furnished as inpatient procedures, the commenter believes that they meet the criteria for inclusion on the ASC list because they do not involve major or prolonged invasion of a body cavity, do not involve major blood loss, intra-operative time is less than 90 minutes, and recovery time is only 60 minutes.

Response: As displayed, the procedures that the commenter has requested as additions to the ASC list are performed predominantly as inpatient procedures. Even CPT code 63030, the procedure for which addition was requested by several commenters, is performed in the outpatient department only 14 percent of the time and is otherwise performed on an inpatient basis. We do not believe that any of these is appropriate for addition to the ASC list.

Comment: We received comments requesting that we add CPT code 65820, Goniotomy, to the Medicare ASC list. The commenters believe that addition of this procedure to the list is appropriate so that beneficiaries who require an inpatient setting due to comorbid conditions or the need for general anesthesia will have the ASC as a choice for the procedure setting.

Response: The site of service data indicate that this procedure is furnished in the physician office 40 percent of the time, in the outpatient department 25 percent of the time, and in the ASC 34 percent of the time. We believe that adding it to the Medicare ASC list is appropriate at this time. We will assign CPT code 65820 to payment group 1.

Comment: We received a few requests that we add CPT code 65771, Radial keratotomy, to the ASC list.

Response: Radial keratotomy is not a Medicare-covered procedure and will not be added to the Medicare ASC list.

Comment: We received a number of comments requesting that we add to the list the following laser procedures that treat some of the most common forms of vision loss and blindness in elderly Americans:

65855 Trabeculoplasty by laser surgery

66711 Ciliary body destruction; cyclophotocoagulation endoscopic

66761 Iridotomy/iridectomy by laser surgery

67028 Intravitreal injection of a pharmacologic agent

67105 Repair retinal detachment, photocoagulation

67110 Repair retinal detachment by injection of air or other gas

67145 Prophylaxis of retinal detachment, photocoagulation

67210 Destruction of retinal lesions, photocoagulation

67220 Destruction of localized lesion of choroid; photocoagulation

67221 Destruction of localized lesion of choroid, photodynamic therapy

67228 Destruction of extensive or progressive retinopathy, photocoagulation

The commenters stated that these procedures should be added to the list because they meet the criteria for inclusion. The intra-operative time is 15 to 20 minutes, recovery time is 40 to 60 minutes, no major blood vessels are encountered during the procedures, and anesthesia is rarely required. Further, commenters stated that, because CPT code 66821, Discission of secondary membranous cataract, laser surgery, is on the list, the other laser procedures should be included as well.

Response: We reviewed these codes and, with the exception of new CPT code 66711, all of these codes usually are performed in the physician office. The new CPT code 66711 is a procedure that has been included on the ASC list as part of CPT code 66710, Ciliary body destruction, cyclophotocoagulation, until January 2005 when CPT code 66710 was redefined and CPT code 66711 was implemented. For the other procedures the commenter listed, except for CPT code 66761, the physician office is the site of service for the procedures more than 80 percent of the time. The predominant site of service for CPT code 66761 also is the office, with 68 percent of procedures furnished in that

setting. Therefore, we will add only 66711 to the ASC list at this time.

Comment: A number of commenters requested that we add CPT code 67445, Orbitotomy with bone flap or window, with removal of bone for decompression, to the Medicare ASC ist.

Response: The procedure is performed 58 percent of the time in the outpatient department and is virtually never performed in the physician office. We agree with the commenter and will add CPT code 67445 to the ASC list and will assign it to payment group 5.

Comment: We received a comment requesting that we add CPT code 67570, Optic nerve decompression, to the ASC list.

Response: The procedure is performed 66 percent of the time in the outpatient department and is virtually never performed in the physician office. We agree with the commenter and will add CPT code 67570 to the Medicare ASC list and will assign it to payment group 4.

Comment: Several commenters requested that we add CPT codes 67810, Biopsy of eyelid; 67825, Trichiasis, epilation by other than forceps; 67840, Excision of lesion of eyelid without closure or with simple direct closure; and 67850, Destruction of lesion of lid margin, to the Medicare ASC list.

Response: These codes are performed in the physician office 88 to 95 percent of the time. Because these procedures are seldom performed in any other setting, we will not add them to the ASC list.

Comment: Several commenters requested that we add CPT code 67912, Correction of lagophthalmos, with implantation of upper eyelid load, to the Medicare ASC list. They stated that the procedure is commonly performed to treat paralyzed upper eyelids that are sometimes the result of cardiovascular accidents (stroke). The procedure should be performed in a sterile environment and, although general anesthesia is rarely used, performance of the procedure in an operating room is preferable in many cases.

Response: This was a new code for 2004, but using CPT code 67911, Correction of lid retraction, as a comparative, we examined the site of service data. We discovered that CPT code 67911 is performed in the physician office only 8 percent of the time; the rest of the time it is performed in outpatient settings. For this reason, we believe that CPT code 67912 should be added to the ASC list, and we will assign it to payment group 3.

Comment: A few commenters wrote to request that we add CPT codes 68100, Biopsy of conjunctiva; and 68110, Excision of lesion, conjunctiva, to the Medicare ASC list.

Response: These two procedures are performed in the physician office more that 50 percent of the time and so will not be added to the ASC list.

Comment: We received a few requests to add CPT codes 68400, Incision, drainage lacrimal gland; 68420, Incision, drainage of lacrimal sac; and 68530, Removal of foreign body or dacryolith, lacrimal passages, to the Medicare ASC list.

Response: These procedures are performed in the physician office more than 80 percent of the time and so will not be added to the ASC list.

Comment: We received one comment requesting that CPT codes 65780, Ocular surface reconstruction; amniotic membrane transplantation; 65781, Ocular surface reconstruction; limbal stem cell allograft; and 65782, Ocular surface reconstruction; limbal conjunctival autograft, be added to the Medicare ASC list.

Response: These were new codes in 2004 and, based on the site of service data for other corneal procedures and the judgment of our medical staff, we believe that these

procedures should be included on the Medicare ASC list, and we will assign them to payment group 5.

Comment: We received a comment requesting that we add CPT code 68371, Harvesting conjunctival allograft, living donor, to the ASC list.

Response: This code was new for 2004, and we have no site of service data to use in our decision-making. Our medical staff determined, however, that this procedure is appropriate for addition to the ASC list, consistent with other procedures currently on the list, CPT codes 68360, Conjunctival flap; bridge or partial; and 68362, Conjunctival flap; total. We will add it to the ASC list and assign it to payment group 2.

Comment: We also received comments requesting that several other ophthalmology codes be added to the list. These are: CPT codes 66990, Use of ophthalmic endoscope; 21386, Open treatment of orbital floor blowout fracture; periorbital approach; 21390, Open treatment orbital floor blowout fracture; periorbital approach, with alloplastic or other implant; 21406, Open treatment of fracture of orbit; except blowout; without implant; and 21407, Open treatment of fracture of orbit; except blowout; with implant. The commenters asserted that these procedures are not performed

in the physician office and that they qualify as procedures suitable for the ASC.

Response: CPT code 66990 does not represent a surgical procedure, and we do not believe that it is an appropriate addition to the ASC list. The code is used to recognize the use of equipment that is integral to surgical procedures. The three CPT codes, 21390, 21406, and 21407, are performed predominantly in the hospital setting. Our medical staff believes that these procedures require more than 4 hours of recovery time and that the hospital site of service is the most appropriate. Therefore, we will not add them to the list.

Comment: We received one comment requesting that we add the following procedures to the Medicare ASC list:

CPT code	Short descriptor	Percent furnished as an in-patient procedure
33206	Insertion of heart pacemaker	81.4
33207	Insertion of heart pacemaker	85.6
33208	Insertion of heart pacemaker	86.7
33212	Insertion of pulse generator	43.4
33213	Insertion of pulse generator	40.3
33214	Upgrade of pacemaker system	68.5
33215	Reposition pacing-defib lead	77.3
33216	Insert lead pace-defib, one	73.3
33217	Insert lead pace-defib, dual	76.7
33233	Removal of pacemaker system	47.4
33234	Removal of pacemaker system	79.6
33235	Removal pacemaker electrode	84.3

The commenter requested that we add these codes and create a new payment group to accommodate the costs for these procedures.

Response: With the exception of CPT codes 33212, 33213, and 33233, we do not believe that these codes are appropriate for the ASC setting because they are performed predominantly on an inpatient basis. However, our medical staff agrees that the procedures coded as CPT codes 33212, 33213, and 33233 are appropriate for inclusion of the ASC list. We will add these codes and will assign CPT codes 33212 and 33213 to payment group 3 and CPT code 33233 to payment group 2.

Comment: We received one comment requesting that we add the following codes to the Medicare ASC list:

CPT Code	Short Descriptor	Percent furnished as an inpatient procedure
35470	Repair arterial blockage	67.5
35471	Repair arterial blockage	57.3
35472	Repair arterial blockage	60.8
35473	Repair arterial blockage	54.2
35474	Repair arterial blockage	56.2
35490	Atherectomy, percutaneous	59.5
35491	Atherectomy, percutaneous	78.9
35492	Atherectomy, percutaneous	69.7
35493	Atherectomy, percutaneous	66.2
35494	Atherectomy, percutaneous	53.1

35495	Atherectomy, percutaneous	67.2
36200	Place catheter in aorta	45.7
36215	Place catheter in artery	46.7
36216	Place catheter in artery	47.2
36217	Place catheter in artery	59.1
36218	Place catheter in artery	55.0
36245	Place catheter in artery	55.5
36246	Place catheter in artery	51.5
36247	Place catheter in artery	57.7
36248	Place catheter in artery	60.5

The commenter believes that the listed procedures are appropriate for performance in an ASC setting because they meet the clinical criteria for inclusion.

Specifically, the commenter stated that CPT codes 35470, 35471, 35473, and 35474 are less invasive than CPT codes 37205, Transcatheter placement of an intravascular stent(s), (except coronary, carotid, and vertebral vessel) percutaneous, initial vessel; and 37206 Transcatheter placement of an intravascular stent(s), (except coronary, carotid, and vertebral vessel) percutaneous, each additional vessel, which we proposed to add to the ASC list in the November 26, 2004 proposed rule. The commenters also stated that CPT codes 35490, 35491, 35492, 35493, 35494, and 35495 should be added if we are making final our proposal to add CPT codes 35475, Transluminal balloon

angioplasty; brachiocephalic trunk or branches; and 35476, Transluminal balloon angioplasty; venous, to the list.

Response: We are reluctant to add CPT codes 35470, 35471, 35473, 35474, 35490, 35491, 35492, 35493, 35494, or 35495 to the ASC list. The procedures are performed in either the outpatient or inpatient departments of the hospital; and the distribution between the two settings is about even although most are performed somewhat more frequently on an inpatient basis. There is almost no utilization of the ASC or physician office settings. We believe that this is indicative of a level of clinical complexity that requires immediate access to the facilities available in the hospital and are not available in either the office or ASC settings. These procedures require more than 4 hours of recovery time and involve major blood vessels and do not meet our clinical criteria for inclusion on the ASC list. We will not add these procedures to the ASC list at this time. Furthermore, as explained in section II above, we reevaluated our proposal to add CPT codes 35475, 35476, 37205, and 37206 to the ASC list and have determined that they are more appropriately limited to the hospital outpatient and inpatient settings at this time.

Similarly, based on their clinical judgment and site of service data, our clinical staff considers all of the other procedures on this list to be predominantly inpatient procedures and not appropriate for addition to the ASC list.

Comment: We received a comment requesting that we add new CPT codes 36475, Endovenous ablation therapy of incompetent vein, extremity, inclusive of all imaging guidance and monitoring, percutaneous, radiofrequency; first vein, 36476, Endovenous ablation therapy of incompetent vein, extremity, inclusive of all imaging guidance and monitoring, percutaneous, radiofrequency; second and subsequent veins in single extremity, each through separate access sites; 36478, Endovenous ablation therapy of incompetent vein, extremity, inclusive of all imaging guidance and monitoring, percutaneous, laser; first vein; and 36479, Endovenous ablation therapy of incompetent vein, extremity, inclusive of all imaging guidance and monitoring, percutaneous, laser; second and subsequent veins treated in a single extremity, each through separate access sites, to the ASC list. The commenter believes that the thermal ablation procedures are appropriate for performance in the ASC.

Response: The codes represent a new technology, and we do not have site of service data for these codes or comparable codes to use to support our decision to add them to the list of procedures on the ASC list. Based on clinical information and indications for use of the procedures, our medical staff believes that these codes are appropriate for the ASC setting and recommends that we add them to the ASC list. We will assign the codes to payment group 3 consistent with other procedures with similar clinical indications.

Comment: We received one comment requesting that we add CPT codes 36100, Introduction of needle or intracatheter, carotid or vertebral artery; 36120, Introduction of needle or intracatheter; retrograde brachial artery; 36140, Introduction of needle or intracatheter; extremity artery; and 36145, Introduction of needle or intracatheter; arteriovenous shunt created for dialysis, to the Medicare ASC list. The commenter believes that these procedures satisfy our criteria for inclusion on the list because they are integral to the surgical procedures for stent placement and other surgeries. The commenter believes that these procedures should receive separate payment in the ASC.

Response: These codes represent procedures that are components of other procedures and are not typically performed alone. As components of other procedures, they do not qualify as appropriate additions to the ASC list. Similar to the OPPS, the ASC payment system does not recognize for separate payment procedures that are integral to the performance of the primary surgical procedure.

Comment: We received one comment requesting that we add CPT Level III code 0020T, Extracorporeal shock wave therapy for plantar facsitits, to the ASC list. The commenter stated that this procedure was recently approved by the CPT Editorial Panel to be changed to a Category I code in 2006 and therefore, we should add the new code, CPT code 2825X, to the ASC list. The commenter believes that because the equipment necessary to perform this treatment is expensive, the service is not typically available in physician offices and is more common in the ASC setting.

Response: Although there will be a Level I CPT code for this service in 2006, there is not one now and so, we will not add this procedure to the list.

Comment: A commenter requested that we add CPT code 28108, Excision or curretage of bone cyst or benign tumor, phalanges of foot, to the ASC list because all of the other

related CPT codes (28106 28107, 28110, etc.) are on the list. The commenter believes that CPT code 28108 is like the codes that are already on the list.

Response: We agree with the commenter that CPT code 28108 is very similar to other CPT codes in that group, and we will add it to the list in payment group 2.

Comment: One commenter requested that we add CPT codes 28230, Tenotomy, open, tendon flexor; foot, single or multiple tendon(s); and 28232, Tenotomy, open, tendon flexor; toe, single tenson, to the list because they are comparable to CPT code 28234, which is on the list.

Response: CPT codes 28230 and 28232 are components of other procedures and are not comparable to CPT code 28234, which is a separate, stand-alone procedure. Because the procedures are components of other procedures, we do not believe it is appropriate to add these codes to the ASC list for separate payment.

Comment: We received a few comments requesting that we add CPT code 58565, Hysteroscopy, with bilateral fallopian tube cannulation to induce occlusion by placement of permanent implants, to the ASC list. This is a new code for 2005 and was created to allow for more coding specificity.

Response: Our medical staff determined that this code is an appropriate addition to the ASC list based on the other hysteroscopy codes currently included on the list. We will add it to the ASC list and assign it to payment group 4.

Comment: We received one comment requesting that we add a number of urologic and gynecologic codes. The codes requested for addition are displayed in the table below:

CPT Code	Descriptor
51741	Complex uroflowmetry
51784	Electromyography studies (EMG) of anal or urethral sphincter, other than needle
51795	Voiding pressure studies (VP); bladder voiding pressure
51797	Voiding pressure studies; intrabdominal voiding pressure (AP)
58260	Vaginal hysterectomy, for uterus ≤ 250 gms
58262	Vaginal hysterectomy, w/ removal of tube(s), &/or ovary(s)
58263	Vaginal hysterectomy, w/removal tube(s), &/or ovary(s), w/repair enterocele
58267	Vaginal hysterectomy, w/colpo-urethrocystopexy with or w/o endoscopic
58270	Vaginal hysterectomy, w/repair enterocele
58275	Vaginal hysterectomy, w/total or partial vaginectomy
58280	Vaginal hysterectomy, w/total or partial vaginectomy, w/ repair enterocele
58290	Vaginal hysterectomy, for uterus > 250 gms
58291	Vaginal hysterectomy for uterus > 250 gms w/removal of tube(s) &/or ovary(s)
58292	Vaginal hysterectomy for uterus > 250 gms w/remove of tube(s) &/or ovary(s), w/repair of enterocele
58293	Vaginal hysterectomy for uterus > 250 gms,

	w/colpo-urethrocystopexy with or w/o endoscopic control
58294	Vaginal hysterectomy for uterus > 250 gms, w/ repair of enterocele
58356	Endometrial cryoablation w/ultrasonic guidance, including endometrial curettage
58552	Laparoscopy surgical, w/vaginal hysterectomy, for uterus ≤ 250 gms, w/removal of tube(s) &/or ovary(s)
58553	Laparoscopy surgical, w/vaginal hysterectomy, for uterus ≥ 250 gms
58554	Laparoscopy surgical, w/vaginal hysterectomy, for uterus ≤ 250 gms, w/removal of tube(s) &/or ovary(s)

Generally, the commenter believes that the listed codes should be added to the ASC list because the physician should be allowed to select the most appropriate setting for performance of procedures. The commenter identified a few codes that are included on the ASC list that the commenter believes are comparable to several of the codes for which addition is being solicited. For example, the commenter indicates that because CPT code 58550, Laparoscopy surgical, with vaginal hysterectomy for uterus 250 grams or less, is included on the list, CPT codes 58552, 58553, and 58554 also should be included and that the inclusion of CPT code 51772, urethral pressure profile studies is an indication that CPT code 51741 should be added to the list.

Response: We do not believe that any of the codes listed is appropriate for addition to the ASC list. CPT codes 51741, 51784, 51795, and 51797 are performed in the physician office setting 80 percent or more of the time and so do not meet our criteria for inclusion on the ASC list. The other listed procedures are furnished as inpatient procedures most of the time and require more than 4 hours of recovery time and so do not meet the criteria for inclusion on the ASC list. We do not believe that addition to the ASC list is appropriate for these codes at this time.

Comment: We received one comment requesting the addition to the ASC list of the following procedures:

CPT Code	Descriptor
58970	Follicle puncture for oocyte retrieval
58974	Embryo transfer, intrauterine
58976	Gamete, zygote, or embryo intrafallopian transfer, any method

The commenter believes that the physician should have the freedom to select the most appropriate site of service for performance of these procedures.

Response: These procedures are performed predominantly in the outpatient department, and we believe

that they satisfy the criteria for inclusion on the ASC list. We will add the procedures to the list and assign all of them to payment group 1.

Comment: We received a comment requesting that we add CPT code 64435, Injection, anesthetic agent; paracervical (uterine) nerve, to the ASC list.

Response: This is a procedure that is predominantly performed in the physician office and as such is not appropriate for inclusion of the ASC list.

Comment: We received several comments asking us to add brachytherapy codes:

CPT code	Descriptor
13153	Repair, complex, eyelids, nose, ears and /or lips;each additional 5cm or less
19295	Image guided placement, metallic localization clip, percutaneous, during breast biopsy
19296	Placement of radiotherapy afterloading balloon catheter into the breast for interstitial radioelement application following partial mastectomy, includes imaging guidance; on date separate from partial mastectomy
19297	Placement of radiotherapy afterloading balloon catheter into the breast for interstitial radioelement application following partial mastectomy, includes imaging guidance; concurrent with partial mastectomy
19298	Placement of radiotherapy afterloading brachytherapy catheters into the breast for interstitial radioelement application following partial mastectomy, includes imaging guidance
57155	Insertion of uterine tandems and/or vaginal ovoids for clinical brachytherapy

58346	Insertion of Heyman capsules for clinical brachytherapy

Response: Procedures represented by CPT codes 13153, 19295, and 19297 are “add-on” procedures that are included in another procedure and are not performed on their own. We do not typically approve this type of procedure for addition to the ASC list as the facility costs for the additional work included in the procedure is not usually significant. That is, the resources required to perform a procedure with or without also performing an “add-on” procedure are not significantly different. Time in the operating suite, supplies, and other resources that Medicare pays for in the ASC, are not significantly increased by performance of the additional procedure. Therefore, under the current rate-setting method, we cannot accurately identify a separate price for “add-on” procedures. We will not add CPT codes 13153, 19295, or 19297 to the ASC list.

However, we agree with the commenters that CPT codes 19296, 19298, 57155, and 58346 meet our criteria and should be added to the ASC list. We also agree that uterine and breast brachytherapy are appropriate services for the ASC

setting. While we are adding these procedure codes to the list, these codes alone do not comprise a brachytherapy procedure. Similar to the performance of prostate brachytherapy, the codes for uterine and breast brachytherapy are among several procedures that may be furnished in the performance of uterine or breast brachytherapy and do not include the application of seeds.

We are currently trying to resolve a number of payment options related to the performance of prostate brachytherapy and the extent to which those services could be paid for when furnished in an ASC under existing regulations related both to ASCs and other payment systems such as the Medicare physician fee schedule. The issues are very complex, and we are still exploring various options. Until we address them comprehensively through national instructions, payment for uterine or breast brachytherapy performed in an ASC is determined by local carriers.

Comment: We received one comment requesting that we place CPT code 50590, Extracorporeal Shock Wave Lithotripsy, on the list of approved ASC procedures.

Response: We had proposed to add this code in our June 1998 proposed rule with a proposed payment of $2,107.

The American Lithotripsy Society opposed the $2,107 payment rate. In American Lithotripsy Society v. Sullivan, 785 F. Supp. 1035 (D.D.C. 1992), the District Court ordered that we "publish the data and other information we are relying on in setting a (lithotripsy) rate and allow time for comment before issuing a final notice * * *." The data and other information that we would rely on in setting a payment rate for ESWL are part of the ratesetting methodology that we proposed in the June 1998 proposed rule. Because we are not making that ratesetting methodology final at this time, we might not be in compliance with the District Court order if we were to add CPT code 50590 to the ASC list in this interim final rule under the current payment rate structure. Therefore, we are not adding CPT code 50590 to the ASC list at this time.

Table 7: Final Additions to the ASC List, Effective July 2005

CPT code	Short descriptor	Payment Group	Payment
15001	Skin graft add-on	1	$333
15836	Excise excessive skin tissue	3	$510
15839	Excise excessive skin tissue	3	$510

19296	Place po breast cath for rad	9	$1,339
19298	Place breast rad tube/caths	1	$333
21120	Reconstruction of chin	7	$995
21125	Augmentation, lower jaw bone	7	$995
28108	Removal of toe lesions	2	$446
29873	Knee arthroscopy/surgery	3	$510
30220	Insert nasal septal button	3	$510
31545	Remove vc lesion w/scope	4	$630
31546	Remove vc lesion scope/graft	4	$630
31603	Incision of windpipe	1	$333
31636	Bronchoscopy, bronch stents	2	$446
31637	Bronchoscopy, stent add-on	1	$333
31638	Bronchoscopy, revise stent	2	$446
33212	Insertion of pulse generator	3	$510
33213	Insertion of pulse generator	3	$510
33233	Removal of pacemaker system	2	$446
36475	Endovenous rf, 1st vein	3	$510
36476	Endovenous rf, vein add-on	3	$510
36478	Endovenous laser, 1st vein	3	$510
36479	Endovenous laser vein addon	3	$510
36834	Repair AV aneurysm	3	$510
37500	Endoscopy ligate perf veins	3	$510
42665	Ligation of salivary duct	7	$995
43237	Endoscopic us exam, esoph	2	$446
43238	Uppr gi endoscopy w/us fn bx	2	$446

44397	Colonoscopy w/stent	1	$333
45327	Proctosigmoidoscopy w/stent	1	$333
45341	Sigmoidoscopy w/ultrasound	1	$333
45342	Sigmoidoscopy w/us guide bx	1	$333
45345	Sigmoidoscopy w/stent	1	$333
45387	Colonoscopy w/stent	1	$333
45391	Colonoscopy w/endoscope us	2	$446
45392	Colonoscopy w/endoscopic fnb	2	$446
46230	Removal of anal tags	1	$333
46706	Repr of anal fistula w/glue	1	$333
46947	Hemorrhoidopexy by stapling	3	$510
49419	Insrt abdom cath for chemotx	1	$333
51992	Laparo sling operation	5	$717
52301	Cystoscopy and treatment	3	$510
52402	Cystourethro cut ejacul duct	3	$510
57155	Insert uteri tandems/ovoids	2	$446
57288	Repair bladder defect	5	$717
58346	Insert heyman uteri capsule	2	$446
58565	Hysteroscopy, sterilization	4	$630
58970	Retrieval of oocyte	1	$333
58974	Transfer of embryo	1	$333

58976	Transfer of embryo	1	$333
62264	Epidural lysis on single day	1	$333
64517	N block inj, hypogastric plexus	2	$446
64561	Implant neuroelectrodes	3	$510
64581	Implant neuroelectrodes	3	$510
64681	Injection treatment of nerve	2	$446
65780	Ocular reconst, transplant	5	$717
65781	Ocular reconst, transplant	5	$717
65782	Ocular reconst, transplant	5	$717
65820	Relieve inner eye pressure	1	$333
66711	Ciliary endoscopic ablation	2	$446
67343	Release eye tissue	7	$995
67445	Explr/decompress eye socket	5	$717
67570	Decompress optic nerve	4	$630
67912	Correction eyelid w/implant	3	$510
68371	Harvest eye tissue, alograft	2	$446

III. Collection of Information Requirements

This document does not impose information collection and recordkeeping requirements. Consequently, it need not be reviewed by the Office of Management and Budget under the authority of the Paperwork Reduction Act of 1995 (44 U.S.C. 35).

IV. Waiver of Proposed Rulemaking

We ordinarily publish this list and propose payment amounts for new items and propose deletions of items in a

notice of proposed rulemaking, subject to public comments. We published such a notice in November 2004. In response to the proposed rule, we received and acted upon a large number of public comments. Commenters requested the addition of a number of procedures to the list; we have added a number of procedures to the list, and we have assigned them to payment groups. Despite the fact that we view these additions as logical outgrowths of our proposed rule, we have decided to provide an opportunity for public comment on the procedures and payment group assignments which were not contained in the proposed rule. Nonetheless, payment will be made, beginning July 5, 2005, based on the list and payment groups contained in this rule.

With respect to the procedures added to the ASC list since the proposed rule, we are waiving our usual notice and comment process. Those procedures will be used effective July 5, 2005 as though they had been included in the proposed rule. We believe that waiving the notice and comment process with respect to those procedures is in the public interest. If notice and comment were not waived, we could not add the procedures suggested by public comments to the list of procedures that may be performed in ASCs.

This result could be detrimental to beneficiaries, who might be unable to receive the procedures in an ambulatory setting. Therefore, we find good cause to waive notice and opportunity for comment with regard to the changes being made to the ASC list which were not published in the proposed rule.

V. Regulatory Impact Statement

[If you choose to comment on issues in this section, please include the caption “REGULATORY IMPACT STATEMENT” at the beginning of your comments.]

A. Overall Impact

We have examined the impact of this rule as required by Executive Order 12866 (September 1993, Regulatory Planning and Review), the Regulatory Flexibility Act (RFA) (September 16, 1980, Pub. L. 96-354), section 1102(b) of the Social Security Act, the Unfunded Mandates Reform Act of 1995 (Pub. L. 104-4), and Executive Order 13132.

Executive Order 12866 directs agencies to assess all costs and benefits of available regulatory alternatives and, if regulation is necessary, to select regulatory approaches that maximize net benefits (including potential economic, environmental, public health and safety effects, distributive impacts, and equity). A regulatory impact

analysis (RIA) must be prepared for major rules with economically significant effects ($100 million or more in any 1 year). Our actuary has prepared a fiscal impact estimate. As shown in the table below, for fiscal years 2005 through 2009, the estimated effect on Medicare program expenditures that result from the additions to and deletions from the ASC list made final in this rule are estimated to have zero impact in 2005, increasing to $5 million savings per year for 2006 through 2009. We expect the estimated savings to result from approximately 10 percent of the procedures proposed for addition moving to a less costly ASC setting from the hospital. This interim final rule will not have a major impact on the Medicare budget.

FY	Cost (Tens of $ millions)
2005	0
2006	-5
2007	-5
2008	-5
2009	-5

The RFA requires agencies to analyze options for regulatory relief of small businesses. For purposes of the RFA, small entities include small businesses, nonprofit organizations, and government agencies. Most hospitals and most other providers and suppliers are small entities, either because of their nonprofit status or because they have revenues of $6 million to $29 million in any 1 year. According to small business associations, approximately 73 percent of all ASCs are considered small entities because they have revenues of $11.5 million or less. Individuals and States are not included in the definition of a small entity.

Section 1102(b) of the Act requires us to prepare a regulatory impact analysis if a final rule may have a

significant impact on the operations of a substantial number of small rural hospitals. This analysis must conform to the provisions of section 604 of the RFA. For purposes of section 1102(b) of the Act, we define a small rural hospital as a hospital that is located outside of a Metropolitan Statistical Area and has fewer than 100 beds. This interim final rule does not have a significant impact on the operations of small rural hospitals.

Section 202 of the Unfunded Mandates Reform Act of 1995 also requires that agencies assess anticipated costs and benefits before issuing any rule that may result in expenditure in any 1 year by State, local or tribal governments, in the aggregate, or by the private sector, of $110 million. This rule will not have an effect on the governments mentioned, and the private sector costs will be less than the $110 million threshold.

Executive Order 13132 establishes certain requirements that an agency must meet when it promulgates a final rule that imposes substantial direct requirement costs on State and local governments, preempts State law, or otherwise has Federalism implications. This rule will not have a substantial effect on State or local governments.

B. Anticipated Effects

The entities affected by this interim final rule are Medicare certified ASCs, physician offices and clinics, hospitals, and beneficiaries. No other providers are affected. This rule will not affect State or local governments. There are more than 4,000 ASCs currently certified by Medicare, nearly three-quarters of which fit the definition of a “small entity”.

This interim final rule revises the ASC list by adding 67 procedures and deleting five. Professional societies, physicians, ASC administrators, and ASC associations recommended most of the codes proposed for addition to the ASC list. Currently, the procedures that we propose to add to the ASC list are performed predominantly in a hospital outpatient setting. Our medical advisors agree that the proposed additions meet the criteria for ASC procedures that are discussed in section II of this preamble and that they can be safely and appropriately performed in an ASC.

Currently, if a physician performed one of the 67 procedures before the effective date of this rule, Medicare would not allow payment to the ASC. Addition of these procedures to the ASC list may benefit ASCs because it will allow Medicare to pay the facility fee to the ASC when the

procedures are furnished there. Further, the additional procedures may increase the number of beneficiaries to whom the ASC can offer its services.

Beneficiaries may benefit from the additions to the ASC list because they will have an additional service setting that they and their physicians may consider for elective surgical procedures and the copayment amounts for services furnished in the ASC setting may be lower than in the hospital outpatient department where many of these procedures currently are furnished.

We estimate that approximately 25 percent of the newly–added procedures that are currently furnished in the physician office will migrate to an ASC setting. This may increase Medicare program spending and beneficiary copayment amounts because the ASC facility fees for these procedures often exceed changes in the physician office setting.

To the extent that hospital outpatient utilization decreases and ASC utilization increases, the Medicare program will realize a savings because the ASC facility fee for most of the proposed additions to the ASC list is lower than the payment rate for the same procedures under the OPPS. Because hospitals perform a much higher volume of

ambulatory surgeries overall than are performed in ASCs, we do not expect significant hospital revenue losses from procedures proposed for addition to the ASC list shifting to the ASC setting.

In addition, we are deleting five procedures from the existing ASC list. We proposed to delete these codes based on recommendations from physicians or specialty societies because the procedures do not meet our criteria; however, they do not represent a significant volume of procedures furnished in ASCs and so deleting them from the list will have no negative effect on ASCs or beneficiaries. As we explained above, three of the codes that we are proposing to delete are procedures that are being performed primarily in a physician office setting and do not require the more elaborate resources of an ASC to be safely performed, and one is furnished 100 percent of the time as an inpatient procedure. Therefore, we do not believe that deleting these procedures from the ASC list will limit beneficiary access or compromise patient safety. For the above reasons, we are not preparing analyses for either the RFA or section 1102(b) of the Act because we have determined, and we certify, that this interim final rule would not have a significant economic impact on a substantial number of

small entities or a significant impact on the operations of a substantial number of small rural hospitals.

C. Alternatives Considered

We are issuing this interim final rule to meet a statutory requirement to update the list of approved ASC procedures biennially. We last updated the ASC list effective July 1, 2003. We implement the biennial update of the list through notice in the **Federal Register** and give interested parties an opportunity to comment on proposed additions to and deletions from the ASC list. If we do not update the ASC list by July 2005, we would be out of compliance with the statute, and we would be denying beneficiary access to surgical procedures in the ASC setting that meet our criteria and are safely and appropriately performed in an ASC.

In accordance with the provisions of Executive Order 12866, this regulation was reviewed by the Office of Management and Budget.

Authority: (Catalog of Federal Domestic Assistance Program No. 93.774, Medicare--Supplementary Medical Insurance Program)

Dated: _____

_____

Mark B. McClellan

Administrator,

Centers for Medicare

Medicaid Services.

Approved: _____

_____

Michael O. Leavitt,

Secretary.

BILLING CODE 4120-01-P

Addendum-List of Medicare Approved ASC Procedures with Additions and Deletions

'A' indicates that the procedure is being added to the ASC list, as proposed

'A*' indicates that the procedure is being added to the ASC list in response to comment and was not proposed. These additions are open for comment.

'D' indicates that the code is being deleted from the ASC list, as proposed

HCPCS Code	Short Descriptor	Status	ASC Payment Group	ASC Payment Rate
10121	Remove foreign body		2	446.00
10180	Complex drainage, wound		2	446.00
11010	Debride skin, fx		2	446.00
11011	Debride skin/muscle, fx		2	446.00
11012	Debride skin/muscle/bone, fx		2	446.00
11042	Debride skin/tissue		2	446.00
11043	Debride tissue/muscle		2	446.00
11044	Debride tissue/muscle/bone		2	446.00
11404	Removal of skin lesion		1	333.00
11406	Removal of skin lesion		2	446.00
11424	Removal of skin lesion		2	446.00
11426	Removal of skin lesion		2	446.00
11444	Removal of skin lesion		1	333.00
11446	Removal of skin lesion		2	446.00
11450	Removal, sweat gland lesion		2	446.00
11451	Removal, sweat gland lesion		2	446.00
11462	Removal, sweat gland lesion		2	446.00
11463	Removal, sweat gland lesion		2	446.00
11470	Removal, sweat gland lesion		2	446.00
11471	Removal, sweat gland lesion		2	446.00
11604	Removal of skin lesion		2	446.00
11606	Removal of skin lesion		2	446.00
11624	Removal of skin lesion		2	446.00

11626	Removal of skin lesion		2	446.00
11644	Removal of skin lesion		2	446.00
11646	Removal of skin lesion		2	446.00
11770	Removal of pilonidal lesion		3	510.00
11771	Removal of pilonidal lesion		3	510.00
11772	Removal of pilonidal lesion		3	510.00
11960	Insert tissue expander(s)		2	446.00
11970	Replace tissue expander		3	510.00
11971	Remove tissue expander(s)		1	333.00
12005	Repair superficial wound(s)		2	446.00
12006	Repair superficial wound(s)		2	446.00
12007	Repair superficial wound(s)		2	446.00
12016	Repair superficial wound(s)		2	446.00
12017	Repair superficial wound(s)		2	446.00
12018	Repair superficial wound(s)		2	446.00
12020	Closure of split wound		1	333.00
12021	Closure of split wound		1	333.00
12034	Layer closure of wound(s)		2	446.00
12035	Layer closure of wound(s)		2	446.00
12036	Layer closure of wound(s)		2	446.00
12037	Layer closure of wound(s)		2	446.00
12044	Layer closure of wound(s)		2	446.00
12045	Layer closure of wound(s)		2	446.00
12046	Layer closure of wound(s)		2	446.00
12047	Layer closure of wound(s)		2	446.00
12054	Layer closure of wound(s)		2	446.00
12055	Layer closure of wound(s)		2	446.00
12056	Layer closure of wound(s)		2	446.00
12057	Layer closure of wound(s)		2	446.00
13100	Repair of wound or lesion		2	446.00
13101	Repair of wound or lesion		3	510.00
13120	Repair of wound or lesion		2	446.00
13121	Repair of wound or lesion		3	510.00
13131	Repair of wound or lesion		2	446.00
13132	Repair of wound or lesion		3	510.00
13150	Repair of wound or lesion		3	510.00
13151	Repair of wound or lesion		3	510.00
13152	Repair of wound or lesion		3	510.00
13160	Late closure of wound		2	446.00
14000	Skin tissue rearrangement		2	446.00
14001	Skin tissue rearrangement		3	510.00
14020	Skin tissue rearrangement		3	510.00
14021	Skin tissue rearrangement		3	510.00
14040	Skin tissue rearrangement		2	446.00
14041	Skin tissue rearrangement		3	510.00

14060	Skin tissue rearrangement		3	510.00
14061	Skin tissue rearrangement		3	510.00
14300	Skin tissue rearrangement		4	630.00
14350	Skin tissue rearrangement		3	510.00
15000	Skin graft		2	446.00
15001	Skin graft add-on	A	1	333.00
15050	Skin pinch graft		2	446.00
15100	Skin split graft		2	446.00
15101	Skin split graft add-on		3	510.00
15120	Skin split graft		2	446.00
15121	Skin split graft add-on		3	510.00
15200	Skin full graft		3	510.00
15201	Skin full graft add-on		2	446.00
15220	Skin full graft		2	446.00
15221	Skin full graft add-on		2	446.00
15240	Skin full graft		3	510.00
15241	Skin full graft add-on		3	510.00
15260	Skin full graft		2	446.00
15261	Skin full graft add-on		2	446.00
15350	Skin homograft		2	446.00
15351	Skin homograft add-on		2	446.00
15400	Skin heterograft		2	446.00
15401	Skin heterograft add-on		2	446.00
15570	Form skin pedicle flap		3	510.00
15572	Form skin pedicle flap		3	510.00
15574	Form skin pedicle flap		3	510.00
15576	Form skin pedicle flap		3	510.00
15600	Skin graft		3	510.00
15610	Skin graft		3	510.00
15620	Skin graft		4	630.00
15630	Skin graft		3	510.00
15650	Transfer skin pedicle flap		5	717.00
15732	Muscle-skin graft, head/neck		3	510.00
15734	Muscle-skin graft, trunk		3	510.00
15736	Muscle-skin graft, arm		3	510.00
15738	Muscle-skin graft, leg		3	510.00
15740	Island pedicle flap graft		2	446.00
15750	Neurovascular pedicle graft		2	446.00
15760	Composite skin graft		2	446.00
15770	Derma-fat-fascia graft		3	510.00
15775	Hair transplant punch grafts		3	510.00
15776	Hair transplant punch grafts		3	510.00
15820	Revision of lower eyelid		3	510.00
15821	Revision of lower eyelid		3	510.00
15822	Revision of upper eyelid		3	510.00

15823	Revision of upper eyelid		5	717.00
15824	Removal of forehead wrinkles		3	510.00
15825	Removal of neck wrinkles		3	510.00
15826	Removal of brow wrinkles		3	510.00
15828	Removal of face wrinkles		3	510.00
15829	Removal of skin wrinkles		5	717.00
15831	Excise excessive skin tissue		3	510.00
15832	Excise excessive skin tissue		3	510.00
15833	Excise excessive skin tissue		3	510.00
15834	Excise excessive skin tissue		3	510.00
15835	Excise excessive skin tissue		3	510.00
15836	Excise excessive skin tissue	A	3	510.00
15839	Excise excessive skin tissue	A	3	510.00
15840	Graft for face nerve palsy		4	630.00
15841	Graft for face nerve palsy		4	630.00
15845	Skin and muscle repair, face		4	630.00
15876	Suction assisted lipectomy		3	510.00
15877	Suction assisted lipectomy		3	510.00
15878	Suction assisted lipectomy		3	510.00
15879	Suction assisted lipectomy		3	510.00
15920	Removal of tail bone ulcer		3	510.00
15922	Removal of tail bone ulcer		4	630.00
15931	Remove sacrum pressure sore		3	510.00
15933	Remove sacrum pressure sore		3	510.00
15934	Remove sacrum pressure sore		3	510.00
15935	Remove sacrum pressure sore		4	630.00
15936	Remove sacrum pressure sore		4	630.00
15937	Remove sacrum pressure sore		4	630.00
15940	Remove hip pressure sore		3	510.00
15941	Remove hip pressure sore		3	510.00
15944	Remove hip pressure sore		3	510.00
15945	Remove hip pressure sore		4	630.00
15946	Remove hip pressure sore		4	630.00
15950	Remove thigh pressure sore		3	510.00
15951	Remove thigh pressure sore		4	630.00
15952	Remove thigh pressure sore		3	510.00
15953	Remove thigh pressure sore		4	630.00
15956	Remove thigh pressure sore		3	510.00
15958	Remove thigh pressure sore		4	630.00
16015	Treatment of burn(s)		2	446.00
19020	Incision of breast lesion		2	446.00
19100	Bx breast percut w/o image		1	333.00
19101	Biopsy of breast, open		2	446.00
19102	Bx breast percut w/image		2	446.00
19103	Bx breast percut w/device		2	446.00

19110	Nipple exploration		2	446.00
19112	Excise breast duct fistula		3	510.00
19120	Removal of breast lesion		3	510.00
19125	Excision, breast lesion		3	510.00
19126	Excision, addl breast lesion		3	510.00
19140	Removal of breast tissue		4	630.00
19160	Removal of breast tissue		3	510.00
19162	Remove breast tissue, nodes		7	995.00
19180	Removal of breast		4	630.00
19182	Removal of breast		4	630.00
19290	Place needle wire, breast		1	333.00
19291	Place needle wire, breast		1	333.00
19296	Place po breast cath for rad	A*	9	1339.00
19298	Place breast rad tube/caths	A*	1	333.00
19316	Suspension of breast		4	630.00
19318	Reduction of large breast		4	630.00
19324	Enlarge breast		4	630.00
19325	Enlarge breast with implant		9	1,339.00
19328	Removal of breast implant		1	333.00
19330	Removal of implant material		1	333.00
19340	Immediate breast prosthesis		2	446.00
19342	Delayed breast prosthesis		3	510.00
19350	Breast reconstruction		4	630.00
19355	Correct inverted nipple(s)		4	630.00
19357	Breast reconstruction		5	717.00
19366	Breast reconstruction		5	717.00
19370	Surgery of breast capsule		4	630.00
19371	Removal of breast capsule		4	630.00
19380	Revise breast reconstruction		5	717.00
20005	Incision of deep abscess		2	446.00
20200	Muscle biopsy		2	446.00
20205	Deep muscle biopsy		3	510.00
20206	Needle biopsy, muscle		1	333.00
20220	Bone biopsy, trocar/needle		1	333.00
20225	Bone biopsy, trocar/needle		2	446.00
20240	Bone biopsy, excisional		2	446.00
20245	Bone biopsy, excisional		3	510.00
20250	Open bone biopsy		3	510.00
20251	Open bone biopsy		3	510.00
20525	Removal of foreign body		3	510.00
20650	Insert and remove bone pin		3	510.00
20670	Removal of support implant		1	333.00
20680	Removal of support implant		3	510.00
20690	Apply bone fixation device		2	446.00
20692	Apply bone fixation device		3	510.00

20693	Adjust bone fixation device		3	510.00
20694	Remove bone fixation device		1	333.00
20900	Removal of bone for graft		3	510.00
20902	Removal of bone for graft		4	630.00
20910	Remove cartilage for graft		3	510.00
20912	Remove cartilage for graft		3	510.00
20920	Removal of fascia for graft		4	630.00
20922	Removal of fascia for graft		3	510.00
20924	Removal of tendon for graft		4	630.00
20926	Removal of tissue for graft		4	630.00
20975	Electrical bone stimulation		2	446.00
21010	Incision of jaw joint		2	446.00
21015	Resection of facial tumor		3	510.00
21025	Excision of bone, lower jaw		2	446.00
21026	Excision of facial bone(s)		2	446.00
21029	Contour of face bone lesion		2	446.00
21034	Removal of face bone lesion		3	510.00
21040	Removal of jaw bone lesion		2	446.00
21044	Removal of jaw bone lesion		2	446.00
21046	Excision, benign tumor, mandible		2	446.00
21047	Excision, benign tumor, mandible		2	446.00
21050	Removal of jaw joint		3	510.00
21060	Remove jaw joint cartilage		2	446.00
21070	Remove coronoid process		3	510.00
21100	Maxillofacial fixation		2	446.00
21120	Reconstruction of chin	A	7	995.00
21121	Reconstruction of chin		7	995.00
21122	Reconstruction of chin		7	995.00
21123	Reconstruction of chin		7	995.00
21125	Augmentation, lower jaw bone	A	7	995.00
21127	Augmentation, lower jaw bone		9	1,339.00
21181	Contour cranial bone lesion		7	995.00
21206	Reconstruct upper jaw bone		5	717.00
21208	Augmentation of facial bones		7	995.00
21209	Reduction of facial bones		5	717.00
21210	Face bone graft		7	995.00
21215	Lower jaw bone graft		7	995.00
21230	Rib cartilage graft		7	995.00
21235	Ear cartilage graft		7	995.00
21240	Reconstruction of jaw joint		4	630.00
21242	Reconstruction of jaw joint		5	717.00
21243	Reconstruction of jaw joint		5	717.00
21244	Reconstruction of lower jaw		7	995.00
21245	Reconstruction of jaw		7	995.00
21246	Reconstruction of jaw		7	995.00

21248	Reconstruction of jaw		7	995.00
21249	Reconstruction of jaw		7	995.00
21267	Revise eye sockets		7	995.00
21270	Augmentation, cheek bone		5	717.00
21275	Revision, orbitofacial bones		7	995.00
21280	Revision of eyelid		5	717.00
21282	Revision of eyelid		5	717.00
21295	Reconst lwr jaw w/o fixation		1	333.00
21296	Reconst lwr jaw w/fixation		1	333.00
21300	Treatment of skull fracture		2	446.00
21310	Treatment of nose fracture		2	446.00
21315	Treatment of nose fracture		2	446.00
21320	Treatment of nose fracture		2	446.00
21325	Treatment of nose fracture		4	630.00
21330	Treatment of nose fracture		5	717.00
21335	Treatment of nose fracture		7	995.00
21336	Treat nasal septal fracture		4	630.00
21337	Treat nasal septal fracture		2	446.00
21338	Treat nasoethmoid fracture		4	630.00
21339	Treat nasoethmoid fracture		5	717.00
21340	Treatment of nose fracture		4	630.00
21345	Treat nose/jaw fracture		7	995.00
21355	Treat cheek bone fracture		3	510.00
21400	Treat eye socket fracture		2	446.00
21401	Treat eye socket fracture		3	510.00
21421	Treat mouth roof fracture		4	630.00
21440	Treat dental ridge fracture	D	3	510.00
21445	Treat dental ridge fracture		4	630.00
21450	Treat lower jaw fracture		3	510.00
21451	Treat lower jaw fracture		4	630.00
21452	Treat lower jaw fracture		2	446.00
21453	Treat lower jaw fracture		3	510.00
21454	Treat lower jaw fracture		5	717.00
21461	Treat lower jaw fracture		4	630.00
21462	Treat lower jaw fracture		5	717.00
21465	Treat lower jaw fracture		4	630.00
21480	Reset dislocated jaw		1	333.00
21485	Reset dislocated jaw		2	446.00
21490	Repair dislocated jaw		3	510.00
21493	Treat hyoid bone fracture		3	510.00
21494	Treat hyoid bone fracture		4	630.00
21497	Interdental wiring		2	446.00
21501	Drain neck/chest lesion		2	446.00
21502	Drain chest lesion		2	446.00
21555	Remove lesion, neck/chest		2	446.00

21556	Remove lesion, neck/chest		2	446.00
21600	Partial removal of rib		2	446.00
21610	Partial removal of rib		2	446.00
21700	Revision of neck muscle		2	446.00
21720	Revision of neck muscle		3	510.00
21725	Revision of neck muscle		3	510.00
21800	Treatment of rib fracture		1	333.00
21805	Treatment of rib fracture		2	446.00
21820	Treat sternum fracture		1	333.00
21925	Biopsy soft tissue of back		2	446.00
21930	Remove lesion, back or flank		2	446.00
21935	Remove tumor, back		3	510.00
22305	Treat spine process fracture		1	333.00
22310	Treat spine fracture		1	333.00
22315	Treat spine fracture		2	446.00
22505	Manipulation of spine		2	446.00
22900	Remove abdominal wall lesion		4	630.00
23000	Removal of calcium deposits		2	446.00
23020	Release shoulder joint		2	446.00
23030	Drain shoulder lesion		1	333.00
23031	Drain shoulder bursa		3	510.00
23035	Drain shoulder bone lesion		3	510.00
23040	Exploratory shoulder surgery		3	510.00
23044	Exploratory shoulder surgery		4	630.00
23066	Biopsy shoulder tissues		2	446.00
23075	Removal of shoulder lesion		2	446.00
23076	Removal of shoulder lesion		2	446.00
23077	Remove tumor of shoulder		3	510.00
23100	Biopsy of shoulder joint		2	446.00
23101	Shoulder joint surgery		7	995.00
23105	Remove shoulder joint lining		4	630.00
23106	Incision of collarbone joint		4	630.00
23107	Explore treat shoulder joint		4	630.00
23120	Partial removal, collar bone		5	717.00
23125	Removal of collar bone		5	717.00
23130	Remove shoulder bone, part		5	717.00
23140	Removal of bone lesion		4	630.00
23145	Removal of bone lesion		5	717.00
23146	Removal of bone lesion		5	717.00
23150	Removal of humerus lesion		4	630.00
23155	Removal of humerus lesion		5	717.00
23156	Removal of humerus lesion		5	717.00
23170	Remove collar bone lesion		2	446.00
23172	Remove shoulder blade lesion		2	446.00
23174	Remove humerus lesion		2	446.00

23180	Remove collar bone lesion		4	630.00
23182	Remove shoulder blade lesion		4	630.00
23184	Remove humerus lesion		4	630.00
23190	Partial removal of scapula		4	630.00
23195	Removal of head of humerus		5	717.00
23330	Remove shoulder foreign body		1	333.00
23331	Remove shoulder foreign body		1	333.00
23395	Muscle transfer,shoulder/arm		5	717.00
23397	Muscle transfers		7	995.00
23400	Fixation of shoulder blade		7	995.00
23405	Incision of tendon & muscle		2	446.00
23406	Incise tendon(s) & muscle(s)		2	446.00
23410	Repair of tendon(s)		5	717.00
23412	Repair of tendon(s)		7	995.00
23415	Release of shoulder ligament		5	717.00
23420	Repair of shoulder		7	995.00
23430	Repair biceps tendon		4	630.00
23440	Remove/transplant tendon		4	630.00
23450	Repair shoulder capsule		5	717.00
23455	Repair shoulder capsule		7	995.00
23460	Repair shoulder capsule		5	717.00
23462	Repair shoulder capsule		7	995.00
23465	Repair shoulder capsule		5	717.00
23466	Repair shoulder capsule		7	995.00
23480	Revision of collar bone		4	630.00
23485	Revision of collar bone		7	995.00
23490	Reinforce clavicle		3	510.00
23491	Reinforce shoulder bones		3	510.00
23500	Treat clavicle fracture		1	333.00
23505	Treat clavicle fracture		1	333.00
23515	Treat clavicle fracture		3	510.00
23520	Treat clavicle dislocation		1	333.00
23525	Treat clavicle dislocation		1	333.00
23530	Treat clavicle dislocation		3	510.00
23532	Treat clavicle dislocation		4	630.00
23540	Treat clavicle dislocation		1	333.00
23545	Treat clavicle dislocation		1	333.00
23550	Treat clavicle dislocation		3	510.00
23552	Treat clavicle dislocation		4	630.00
23570	Treat shoulder blade fx		1	333.00
23575	Treat shoulder blade fx		1	333.00
23585	Treat scapula fracture		3	510.00
23600	Treat humerus fracture	D	1	333.00
23605	Treat humerus fracture		2	446.00
23615	Treat humerus fracture		4	630.00

23616	Treat humerus fracture		4	630.00
23620	Treat humerus fracture	D	1	333.00
23625	Treat humerus fracture		2	446.00
23630	Treat humerus fracture		5	717.00
23650	Treat shoulder dislocation		1	333.00
23655	Treat shoulder dislocation		1	333.00
23660	Treat shoulder dislocation		3	510.00
23665	Treat dislocation/fracture		2	446.00
23670	Treat dislocation/fracture		3	510.00
23675	Treat dislocation/fracture		2	446.00
23680	Treat dislocation/fracture		3	510.00
23700	Fixation of shoulder		1	333.00
23800	Fusion of shoulder joint		4	630.00
23802	Fusion of shoulder joint		7	995.00
23921	Amputation follow-up surgery		3	510.00
23930	Drainage of arm lesion		1	333.00
23931	Drainage of arm bursa		2	446.00
23935	Drain arm/elbow bone lesion		2	446.00
24000	Exploratory elbow surgery		4	630.00
24006	Release elbow joint		4	630.00
24066	Biopsy arm/elbow soft tissue		2	446.00
24075	Remove arm/elbow lesion		2	446.00
24076	Remove arm/elbow lesion		2	446.00
24077	Remove tumor of arm/elbow		3	510.00
24100	Biopsy elbow joint lining		1	333.00
24101	Explore/treat elbow joint		4	630.00
24102	Remove elbow joint lining		4	630.00
24105	Removal of elbow bursa		3	510.00
24110	Remove humerus lesion		2	446.00
24115	Remove/graft bone lesion		3	510.00
24116	Remove/graft bone lesion		3	510.00
24120	Remove elbow lesion		3	510.00
24125	Remove/graft bone lesion		3	510.00
24126	Remove/graft bone lesion		3	510.00
24130	Removal of head of radius		3	510.00
24134	Removal of arm bone lesion		2	446.00
24136	Remove radius bone lesion		2	446.00
24138	Remove elbow bone lesion		2	446.00
24140	Partial removal of arm bone		3	510.00
24145	Partial removal of radius		3	510.00
24147	Partial removal of elbow		2	446.00
24155	Removal of elbow joint		3	510.00
24160	Remove elbow joint implant		2	446.00
24164	Remove radius head implant		3	510.00
24201	Removal of arm foreign body		2	446.00

24301	Muscle/tendon transfer		4	630.00
24305	Arm tendon lengthening		4	630.00
24310	Revision of arm tendon		3	510.00
24320	Repair of arm tendon		3	510.00
24330	Revision of arm muscles		3	510.00
24331	Revision of arm muscles		3	510.00
24340	Repair of biceps tendon		3	510.00
24341	Repair arm tendon/muscle		3	510.00
24342	Repair of ruptured tendon		3	510.00
24345	Repr elbw med ligmnt w/tissu		2	446.00
24350	Repair of tennis elbow		3	510.00
24351	Repair of tennis elbow		3	510.00
24352	Repair of tennis elbow		3	510.00
24354	Repair of tennis elbow		3	510.00
24356	Revision of tennis elbow		3	510.00
24360	Reconstruct elbow joint		5	717.00
24361	Reconstruct elbow joint		5	717.00
24362	Reconstruct elbow joint		5	717.00
24363	Replace elbow joint		7	995.00
24365	Reconstruct head of radius		5	717.00
24366	Reconstruct head of radius		5	717.00
24400	Revision of humerus		4	630.00
24410	Revision of humerus		4	630.00
24420	Revision of humerus		3	510.00
24430	Repair of humerus		3	510.00
24435	Repair humerus with graft		4	630.00
24470	Revision of elbow joint		3	510.00
24495	Decompression of forearm		2	446.00
24498	Reinforce humerus		3	510.00
24500	Treat humerus fracture		1	333.00
24505	Treat humerus fracture		1	333.00
24515	Treat humerus fracture		4	630.00
24516	Treat humerus fracture		4	630.00
24530	Treat humerus fracture		1	333.00
24535	Treat humerus fracture		1	333.00
24538	Treat humerus fracture		2	446.00
24545	Treat humerus fracture		4	630.00
24546	Treat humerus fracture		5	717.00
24560	Treat humerus fracture		1	333.00
24565	Treat humerus fracture		2	446.00
24566	Treat humerus fracture		2	446.00
24575	Treat humerus fracture		3	510.00
24576	Treat humerus fracture		1	333.00
24577	Treat humerus fracture		1	333.00
24579	Treat humerus fracture		3	510.00

24582	Treat humerus fracture		2	446.00
24586	Treat elbow fracture		4	630.00
24587	Treat elbow fracture		5	717.00
24600	Treat elbow dislocation		1	333.00
24605	Treat elbow dislocation		2	446.00
24615	Treat elbow dislocation		3	510.00
24620	Treat elbow fracture		2	446.00
24635	Treat elbow fracture		3	510.00
24655	Treat radius fracture		1	333.00
24665	Treat radius fracture		4	630.00
24666	Treat radius fracture		4	630.00
24670	Treat ulnar fracture		1	333.00
24675	Treat ulnar fracture		1	333.00
24685	Treat ulnar fracture		3	510.00
24800	Fusion of elbow joint		4	630.00
24802	Fusion/graft of elbow joint		5	717.00
24925	Amputation follow-up surgery		3	510.00
25000	Incision of tendon sheath		3	510.00
25020	Decompress forearm 1 space		3	510.00
25023	Decompress forearm 1 space		3	510.00
25024	Decompress forearm 2 spaces		3	510.00
25025	Decompress forarm 2 spaces		3	510.00
25028	Drainage of forearm lesion		1	333.00
25031	Drainage of forearm bursa		2	446.00
25035	Treat forearm bone lesion		2	446.00
25040	Explore/treat wrist joint		5	717.00
25066	Biopsy forearm soft tissues		2	446.00
25075	Remove forearm lesion subcut		2	446.00
25076	Remove forearm lesion deep		3	510.00
25077	Remove tumor, forearm/wrist		3	510.00
25085	Incision of wrist capsule		3	510.00
25100	Biopsy of wrist joint		2	446.00
25101	Explore/treat wrist joint		3	510.00
25105	Remove wrist joint lining		4	630.00
25107	Remove wrist joint cartilage		3	510.00
25110	Remove wrist tendon lesion		3	510.00
25111	Remove wrist tendon lesion		3	510.00
25112	Reremove wrist tendon lesion		4	630.00
25115	Remove wrist/forearm lesion		4	630.00
25116	Remove wrist/forearm lesion		4	630.00
25118	Excise wrist tendon sheath		2	446.00
25119	Partial removal of ulna		3	510.00
25120	Removal of forearm lesion		3	510.00
25125	Remove/graft forearm lesion		3	510.00
25126	Remove/graft forearm lesion		3	510.00

25130	Removal of wrist lesion		3	510.00
25135	Remove & graft wrist lesion		3	510.00
25136	Remove & graft wrist lesion		3	510.00
25145	Remove forearm bone lesion		2	446.00
25150	Partial removal of ulna		2	446.00
25151	Partial removal of radius		2	446.00
25210	Removal of wrist bone		3	510.00
25215	Removal of wrist bones		4	630.00
25230	Partial removal of radius		4	630.00
25240	Partial removal of ulna		4	630.00
25248	Remove forearm foreign body		2	446.00
25250	Removal of wrist prosthesis		1	333.00
25251	Removal of wrist prosthesis		1	333.00
25260	Repair forearm tendon/muscle		4	630.00
25263	Repair forearm tendon/muscle		2	446.00
25265	Repair forearm tendon/muscle		3	510.00
25270	Repair forearm tendon/muscle		4	630.00
25272	Repair forearm tendon/muscle		3	510.00
25274	Repair forearm tendon/muscle		4	630.00
25275	Repair forearm tendon sheath		4	630.00
25280	Revise wrist/forearm tendon		4	630.00
25290	Incise wrist/forearm tendon		3	510.00
25295	Release wrist/forearm tendon		3	510.00
25300	Fusion of tendons at wrist		3	510.00
25301	Fusion of tendons at wrist		3	510.00
25310	Transplant forearm tendon		3	510.00
25312	Transplant forearm tendon		4	630.00
25315	Revise palsy hand tendon(s)		3	510.00
25316	Revise palsy hand tendon(s)		3	510.00
25320	Repair/revise wrist joint		3	510.00
25332	Revise wrist joint		5	717.00
25335	Realignment of hand		3	510.00
25337	Reconstruct ulna/radioulnar		5	717.00
25350	Revision of radius		3	510.00
25355	Revision of radius		3	510.00
25360	Revision of ulna		3	510.00
25365	Revise radius & ulna		3	510.00
25370	Revise radius or ulna		3	510.00
25375	Revise radius & ulna		4	630.00
25390	Shorten radius or ulna		3	510.00
25391	Lengthen radius or ulna		4	630.00
25392	Shorten radius & ulna		3	510.00
25393	Lengthen radius & ulna		4	630.00
25400	Repair radius or ulna		3	510.00
25405	Repair/graft radius or ulna		4	630.00

25415	Repair radius & ulna		3	510.00
25420	Repair/graft radius & ulna		4	630.00
25425	Repair/graft radius or ulna		3	510.00
25426	Repair/graft radius & ulna		4	630.00
25440	Repair/graft wrist bone		4	630.00
25441	Reconstruct wrist joint		5	717.00
25442	Reconstruct wrist joint		5	717.00
25443	Reconstruct wrist joint		5	717.00
25444	Reconstruct wrist joint		5	717.00
25445	Reconstruct wrist joint		5	717.00
25446	Wrist replacement		7	995.00
25447	Repair wrist joint(s)		5	717.00
25449	Remove wrist joint implant		5	717.00
25450	Revision of wrist joint		3	510.00
25455	Revision of wrist joint		3	510.00
25490	Reinforce radius		3	510.00
25491	Reinforce ulna		3	510.00
25492	Reinforce radius and ulna		3	510.00
25505	Treat fracture of radius		1	333.00
25515	Treat fracture of radius		3	510.00
25520	Treat fracture of radius		1	333.00
25525	Treat fracture of radius		4	630.00
25526	Treat fracture of radius		5	717.00
25535	Treat fracture of ulna		1	333.00
25545	Treat fracture of ulna		3	510.00
25565	Treat fracture radius & ulna		2	446.00
25574	Treat fracture radius & ulna		3	510.00
25575	Treat fracture radius/ulna		3	510.00
25605	Treat fracture radius/ulna		3	510.00
25611	Treat fracture radius/ulna		3	510.00
25620	Treat fracture radius/ulna		5	717.00
25624	Treat wrist bone fracture		2	446.00
25628	Treat wrist bone fracture		3	510.00
25635	Treat wrist bone fracture		1	333.00
25645	Treat wrist bone fracture		3	510.00
25660	Treat wrist dislocation		1	333.00
25670	Treat wrist dislocation		3	510.00
25671	Pin radioulnar dislocation		1	333.00
25675	Treat wrist dislocation		1	333.00
25676	Treat wrist dislocation		2	446.00
25680	Treat wrist fracture		2	446.00
25685	Treat wrist fracture		3	510.00
25690	Treat wrist dislocation		1	333.00
25695	Treat wrist dislocation		2	446.00
25800	Fusion of wrist joint		4	630.00

25805	Fusion/graft of wrist joint		5	717.00
25810	Fusion/graft of wrist joint		5	717.00
25820	Fusion of hand bones		4	630.00
25825	Fuse hand bones with graft		5	717.00
25830	Fusion, radioulnar jnt/ulna		5	717.00
25907	Amputation follow-up surgery		3	510.00
25922	Amputate hand at wrist		3	510.00
25929	Amputation follow-up surgery		3	510.00
26011	Drainage of finger abscess		1	333.00
26020	Drain hand tendon sheath		2	446.00
26025	Drainage of palm bursa		1	333.00
26030	Drainage of palm bursa(s)		2	446.00
26034	Treat hand bone lesion		2	446.00
26040	Release palm contracture		4	630.00
26045	Release palm contracture		3	510.00
26055	Incise finger tendon sheath		2	446.00
26060	Incision of finger tendon		2	446.00
26070	Explore/treat hand joint		2	446.00
26075	Explore/treat finger joint		4	630.00
26080	Explore/treat finger joint		4	630.00
26100	Biopsy hand joint lining		2	446.00
26105	Biopsy finger joint lining		1	333.00
26110	Biopsy finger joint lining		1	333.00
26115	Remove hand lesion subcut		2	446.00
26116	Remove hand lesion, deep		2	446.00
26117	Remove tumor, hand/finger		3	510.00
26121	Release palm contracture		4	630.00
26123	Release palm contracture		4	630.00
26125	Release palm contracture		4	630.00
26130	Remove wrist joint lining		3	510.00
26135	Revise finger joint, each		4	630.00
26140	Revise finger joint, each		2	446.00
26145	Tendon excision, palm/finger		3	510.00
26160	Remove tendon sheath lesion		3	510.00
26170	Removal of palm tendon, each		3	510.00
26180	Removal of finger tendon		3	510.00
26185	Remove finger bone		4	630.00
26200	Remove hand bone lesion		2	446.00
26205	Remove/graft bone lesion		3	510.00
26210	Removal of finger lesion		2	446.00
26215	Remove/graft finger lesion		3	510.00
26230	Partial removal of hand bone		7	995.00
26235	Partial removal, finger bone		3	510.00
26236	Partial removal, finger bone		3	510.00
26250	Extensive hand surgery		3	510.00

26255	Extensive hand surgery		3	510.00
26260	Extensive finger surgery		3	510.00
26261	Extensive finger surgery		3	510.00
26262	Partial removal of finger		2	446.00
26320	Removal of implant from hand		2	446.00
26350	Repair finger/hand tendon		1	333.00
26352	Repair/graft hand tendon		4	630.00
26356	Repair finger/hand tendon		4	630.00
26357	Repair finger/hand tendon		4	630.00
26358	Repair/graft hand tendon		4	630.00
26370	Repair finger/hand tendon		4	630.00
26372	Repair/graft hand tendon		4	630.00
26373	Repair finger/hand tendon		3	510.00
26390	Revise hand/finger tendon		4	630.00
26392	Repair/graft hand tendon		3	510.00
26410	Repair hand tendon		3	510.00
26412	Repair/graft hand tendon		3	510.00
26415	Excision, hand/finger tendon		4	630.00
26416	Graft hand or finger tendon		3	510.00
26418	Repair finger tendon		4	630.00
26420	Repair/graft finger tendon		4	630.00
26426	Repair finger/hand tendon		3	510.00
26428	Repair/graft finger tendon		3	510.00
26432	Repair finger tendon		3	510.00
26433	Repair finger tendon		3	510.00
26434	Repair/graft finger tendon		3	510.00
26437	Realignment of tendons		3	510.00
26440	Release palm/finger tendon		3	510.00
26442	Release palm & finger tendon		3	510.00
26445	Release hand/finger tendon		3	510.00
26449	Release forearm/hand tendon		3	510.00
26450	Incision of palm tendon		3	510.00
26455	Incision of finger tendon		3	510.00
26460	Incise hand/finger tendon		3	510.00
26471	Fusion of finger tendons		2	446.00
26474	Fusion of finger tendons		2	446.00
26476	Tendon lengthening		1	333.00
26477	Tendon shortening		1	333.00
26478	Lengthening of hand tendon		1	333.00
26479	Shortening of hand tendon		1	333.00
26480	Transplant hand tendon		3	510.00
26483	Transplant/graft hand tendon		3	510.00
26485	Transplant palm tendon		2	446.00
26489	Transplant/graft palm tendon		3	510.00
26490	Revise thumb tendon		3	510.00

26492	Tendon transfer with graft		3	510.00
26494	Hand tendon/muscle transfer		3	510.00
26496	Revise thumb tendon		3	510.00
26497	Finger tendon transfer		3	510.00
26498	Finger tendon transfer		4	630.00
26499	Revision of finger		3	510.00
26500	Hand tendon reconstruction		4	630.00
26502	Hand tendon reconstruction		4	630.00
26504	Hand tendon reconstruction		4	630.00
26508	Release thumb contracture		3	510.00
26510	Thumb tendon transfer		3	510.00
26516	Fusion of knuckle joint		1	333.00
26517	Fusion of knuckle joints		3	510.00
26518	Fusion of knuckle joints		3	510.00
26520	Release knuckle contracture		3	510.00
26525	Release finger contracture		3	510.00
26530	Revise knuckle joint		3	510.00
26531	Revise knuckle with implant		7	995.00
26535	Revise finger joint		5	717.00
26536	Revise/implant finger joint		5	717.00
26540	Repair hand joint		4	630.00
26541	Repair hand joint with graft		7	995.00
26542	Repair hand joint with graft		4	630.00
26545	Reconstruct finger joint		4	630.00
26546	Repair nonunion hand		4	630.00
26548	Reconstruct finger joint		4	630.00
26550	Construct thumb replacement		2	446.00
26555	Positional change of finger		3	510.00
26560	Repair of web finger		2	446.00
26561	Repair of web finger		3	510.00
26562	Repair of web finger		4	630.00
26565	Correct metacarpal flaw		5	717.00
26567	Correct finger deformity		5	717.00
26568	Lengthen metacarpal/finger		3	510.00
26580	Repair hand deformity		5	717.00
26587	Reconstruct extra finger		5	717.00
26590	Repair finger deformity		5	717.00
26591	Repair muscles of hand		3	510.00
26593	Release muscles of hand		3	510.00
26596	Excision constricting tissue		2	446.00
26605	Treat metacarpal fracture		2	446.00
26607	Treat metacarpal fracture		2	446.00
26608	Treat metacarpal fracture		4	630.00
26615	Treat metacarpal fracture		4	630.00
26645	Treat thumb fracture		1	333.00

26650	Treat thumb fracture		2	446.00
26665	Treat thumb fracture		4	630.00
26675	Treat hand dislocation		2	446.00
26676	Pin hand dislocation		2	446.00
26685	Treat hand dislocation		3	510.00
26686	Treat hand dislocation		3	510.00
26705	Treat knuckle dislocation		2	446.00
26706	Pin knuckle dislocation		2	446.00
26715	Treat knuckle dislocation		4	630.00
26727	Treat finger fracture, each		7	995.00
26735	Treat finger fracture, each		4	630.00
26742	Treat finger fracture, each		2	446.00
26746	Treat finger fracture, each		5	717.00
26756	Pin finger fracture, each		2	446.00
26765	Treat finger fracture, each		4	630.00
26776	Pin finger dislocation		2	446.00
26785	Treat finger dislocation		2	446.00
26820	Thumb fusion with graft		5	717.00
26841	Fusion of thumb		4	630.00
26842	Thumb fusion with graft		4	630.00
26843	Fusion of hand joint		3	510.00
26844	Fusion/graft of hand joint		3	510.00
26850	Fusion of knuckle		4	630.00
26852	Fusion of knuckle with graft		4	630.00
26860	Fusion of finger joint		3	510.00
26861	Fusion of finger jnt, add-on		2	446.00
26862	Fusion/graft of finger joint		4	630.00
26863	Fuse/graft added joint		3	510.00
26910	Amputate metacarpal bone		3	510.00
26951	Amputation of finger/thumb		2	446.00
26952	Amputation of finger/thumb		4	630.00
26990	Drainage of pelvis lesion		1	333.00
26991	Drainage of pelvis bursa		1	333.00
27000	Incision of hip tendon		2	446.00
27001	Incision of hip tendon		3	510.00
27003	Incision of hip tendon		3	510.00
27033	Exploration of hip joint		3	510.00
27035	Denervation of hip joint		4	630.00
27040	Biopsy of soft tissues		1	333.00
27041	Biopsy of soft tissues		2	446.00
27047	Remove hip/pelvis lesion		2	446.00
27048	Remove hip/pelvis lesion		3	510.00
27049	Remove tumor, hip/pelvis		3	510.00
27050	Biopsy of sacroiliac joint		3	510.00
27052	Biopsy of hip joint		3	510.00

27060	Removal of ischial bursa		5	717.00
27062	Remove femur lesion/bursa		5	717.00
27065	Removal of hip bone lesion		5	717.00
27066	Removal of hip bone lesion		5	717.00
27067	Remove/graft hip bone lesion		5	717.00
27080	Removal of tail bone		2	446.00
27086	Remove hip foreign body		1	333.00
27087	Remove hip foreign body		3	510.00
27097	Revision of hip tendon		3	510.00
27098	Transfer tendon to pelvis		3	510.00
27100	Transfer of abdominal muscle		4	630.00
27105	Transfer of spinal muscle		4	630.00
27110	Transfer of iliopsoas muscle		4	630.00
27111	Transfer of iliopsoas muscle		4	630.00
27193	Treat pelvic ring fracture		1	333.00
27194	Treat pelvic ring fracture		2	446.00
27202	Treat tail bone fracture		2	446.00
27230	Treat thigh fracture		1	333.00
27238	Treat thigh fracture		1	333.00
27246	Treat thigh fracture		1	333.00
27250	Treat hip dislocation		1	333.00
27252	Treat hip dislocation		2	446.00
27257	Treat hip dislocation		3	510.00
27265	Treat hip dislocation		1	333.00
27266	Treat hip dislocation		2	446.00
27275	Manipulation of hip joint		2	446.00
27301	Drain thigh/knee lesion		3	510.00
27305	Incise thigh tendon & fascia		2	446.00
27306	Incision of thigh tendon		3	510.00
27307	Incision of thigh tendons		3	510.00
27310	Exploration of knee joint		4	630.00
27315	Partial removal, thigh nerve		2	446.00
27320	Partial removal, thigh nerve		2	446.00
27323	Biopsy, thigh soft tissues		1	333.00
27324	Biopsy, thigh soft tissues		1	333.00
27327	Removal of thigh lesion		2	446.00
27328	Removal of thigh lesion		3	510.00
27329	Remove tumor, thigh/knee		4	630.00
27330	Biopsy, knee joint lining		4	630.00
27331	Explore/treat knee joint		4	630.00
27332	Removal of knee cartilage		4	630.00
27333	Removal of knee cartilage		4	630.00
27334	Remove knee joint lining		4	630.00
27335	Remove knee joint lining		4	630.00
27340	Removal of kneecap bursa		3	510.00

27345	Removal of knee cyst		4	630.00
27347	Remove knee cyst		4	630.00
27350	Removal of kneecap		4	630.00
27355	Remove femur lesion		3	510.00
27356	Remove femur lesion/graft		4	630.00
27357	Remove femur lesion/graft		5	717.00
27358	Remove femur lesion/fixation		5	717.00
27360	Partial removal, leg bone(s)		5	717.00
27372	Removal of foreign body		7	995.00
27380	Repair of kneecap tendon		1	333.00
27381	Repair/graft kneecap tendon		3	510.00
27385	Repair of thigh muscle		3	510.00
27386	Repair/graft of thigh muscle		3	510.00
27390	Incision of thigh tendon		1	333.00
27391	Incision of thigh tendons		2	446.00
27392	Incision of thigh tendons		3	510.00
27393	Lengthening of thigh tendon		2	446.00
27394	Lengthening of thigh tendons		3	510.00
27395	Lengthening of thigh tendons		3	510.00
27396	Transplant of thigh tendon		3	510.00
27397	Transplants of thigh tendons		3	510.00
27400	Revise thigh muscles/tendons		3	510.00
27403	Repair of knee cartilage		4	630.00
27405	Repair of knee ligament		4	630.00
27407	Repair of knee ligament		4	630.00
27409	Repair of knee ligaments		4	630.00
27418	Repair degenerated kneecap		3	510.00
27420	Revision of unstable kneecap		3	510.00
27422	Revision of unstable kneecap		7	995.00
27424	Revision/removal of kneecap		3	510.00
27425	Lateral retinacular release		7	995.00
27427	Reconstruction, knee		3	510.00
27428	Reconstruction, knee		4	630.00
27429	Reconstruction, knee		4	630.00
27430	Revision of thigh muscles		4	630.00
27435	Incision of knee joint		4	630.00
27437	Revise kneecap		4	630.00
27438	Revise kneecap with implant		5	717.00
27441	Revision of knee joint		5	717.00
27442	Revision of knee joint		5	717.00
27443	Revision of knee joint		5	717.00
27496	Decompression of thigh/knee		5	717.00
27497	Decompression of thigh/knee		3	510.00
27498	Decompression of thigh/knee		3	510.00
27499	Decompression of thigh/knee		3	510.00

27500	Treatment of thigh fracture		1	333.00
27501	Treatment of thigh fracture		2	446.00
27502	Treatment of thigh fracture		2	446.00
27503	Treatment of thigh fracture		3	510.00
27508	Treatment of thigh fracture		1	333.00
27509	Treatment of thigh fracture		3	510.00
27510	Treatment of thigh fracture		1	333.00
27516	Treat thigh fx growth plate		1	333.00
27517	Treat thigh fx growth plate		1	333.00
27520	Treat kneecap fracture		1	333.00
27530	Treat knee fracture		1	333.00
27532	Treat knee fracture		1	333.00
27538	Treat knee fracture(s)		1	333.00
27550	Treat knee dislocation		1	333.00
27552	Treat knee dislocation		1	333.00
27560	Treat kneecap dislocation		1	333.00
27562	Treat kneecap dislocation		1	333.00
27566	Treat kneecap dislocation		2	446.00
27570	Fixation of knee joint		1	333.00
27594	Amputation follow-up surgery		3	510.00
27600	Decompression of lower leg		3	510.00
27601	Decompression of lower leg		3	510.00
27602	Decompression of lower leg		3	510.00
27603	Drain lower leg lesion		2	446.00
27604	Drain lower leg bursa		2	446.00
27605	Incision of achilles tendon		1	333.00
27606	Incision of achilles tendon		1	333.00
27607	Treat lower leg bone lesion		2	446.00
27610	Explore/treat ankle joint		2	446.00
27612	Exploration of ankle joint		3	510.00
27614	Biopsy lower leg soft tissue		2	446.00
27615	Remove tumor, lower leg		3	510.00
27618	Remove lower leg lesion		2	446.00
27619	Remove lower leg lesion		3	510.00
27620	Explore/treat ankle joint		4	630.00
27625	Remove ankle joint lining		4	630.00
27626	Remove ankle joint lining		4	630.00
27630	Removal of tendon lesion		3	510.00
27635	Remove lower leg bone lesion		3	510.00
27637	Remove/graft leg bone lesion		3	510.00
27638	Remove/graft leg bone lesion		3	510.00
27640	Partial removal of tibia		2	446.00
27641	Partial removal of fibula		2	446.00
27647	Extensive ankle/heel surgery		3	510.00
27650	Repair achilles tendon		3	510.00

27652	Repair/graft achilles tendon		3	510.00
27654	Repair of achilles tendon		3	510.00
27656	Repair leg fascia defect		2	446.00
27658	Repair of leg tendon, each		1	333.00
27659	Repair of leg tendon, each		2	446.00
27664	Repair of leg tendon, each		2	446.00
27665	Repair of leg tendon, each		2	446.00
27675	Repair lower leg tendons		2	446.00
27676	Repair lower leg tendons		3	510.00
27680	Release of lower leg tendon		3	510.00
27681	Release of lower leg tendons		2	446.00
27685	Revision of lower leg tendon		3	510.00
27686	Revise lower leg tendons		3	510.00
27687	Revision of calf tendon		3	510.00
27690	Revise lower leg tendon		4	630.00
27691	Revise lower leg tendon		4	630.00
27692	Revise additional leg tendon		3	510.00
27695	Repair of ankle ligament		2	446.00
27696	Repair of ankle ligaments		2	446.00
27698	Repair of ankle ligament		2	446.00
27700	Revision of ankle joint		5	717.00
27704	Removal of ankle implant		2	446.00
27705	Incision of tibia		2	446.00
27707	Incision of fibula		2	446.00
27709	Incision of tibia & fibula		2	446.00
27730	Repair of tibia epiphysis		2	446.00
27732	Repair of fibula epiphysis		2	446.00
27734	Repair lower leg epiphyses		2	446.00
27740	Repair of leg epiphyses		2	446.00
27742	Repair of leg epiphyses		2	446.00
27745	Reinforce tibia		3	510.00
27750	Treatment of tibia fracture		1	333.00
27752	Treatment of tibia fracture		1	333.00
27756	Treatment of tibia fracture		3	510.00
27758	Treatment of tibia fracture		4	630.00
27759	Treatment of tibia fracture		4	630.00
27760	Treatment of ankle fracture		1	333.00
27762	Treatment of ankle fracture		1	333.00
27766	Treatment of ankle fracture		3	510.00
27780	Treatment of fibula fracture		1	333.00
27781	Treatment of fibula fracture		1	333.00
27784	Treatment of fibula fracture		3	510.00
27786	Treatment of ankle fracture		1	333.00
27788	Treatment of ankle fracture		1	333.00
27792	Treatment of ankle fracture		3	510.00

27808	Treatment of ankle fracture		1	333.00
27810	Treatment of ankle fracture		1	333.00
27814	Treatment of ankle fracture		3	510.00
27816	Treatment of ankle fracture		1	333.00
27818	Treatment of ankle fracture		1	333.00
27822	Treatment of ankle fracture		3	510.00
27823	Treatment of ankle fracture		3	510.00
27824	Treat lower leg fracture		1	333.00
27825	Treat lower leg fracture		2	446.00
27826	Treat lower leg fracture		3	510.00
27827	Treat lower leg fracture		3	510.00
27828	Treat lower leg fracture		4	630.00
27829	Treat lower leg joint		2	446.00
27830	Treat lower leg dislocation		1	333.00
27831	Treat lower leg dislocation		1	333.00
27832	Treat lower leg dislocation		2	446.00
27840	Treat ankle dislocation		1	333.00
27842	Treat ankle dislocation		1	333.00
27846	Treat ankle dislocation		3	510.00
27848	Treat ankle dislocation		3	510.00
27860	Fixation of ankle joint		1	333.00
27870	Fusion of ankle joint		4	630.00
27871	Fusion of tibiofibular joint		4	630.00
27884	Amputation follow-up surgery		3	510.00
27889	Amputation of foot at ankle		3	510.00
27892	Decompression of leg		3	510.00
27893	Decompression of leg		3	510.00
27894	Decompression of leg		3	510.00
28002	Treatment of foot infection		3	510.00
28003	Treatment of foot infection		3	510.00
28005	Treat foot bone lesion		3	510.00
28008	Incision of foot fascia		3	510.00
28011	Incision of toe tendons		3	510.00
28020	Exploration of foot joint		2	446.00
28022	Exploration of foot joint		2	446.00
28024	Exploration of toe joint		2	446.00
28030	Removal of foot nerve		4	630.00
28035	Decompression of tibia nerve		4	630.00
28043	Excision of foot lesion		2	446.00
28045	Excision of foot lesion		3	510.00
28046	Resection of tumor, foot		3	510.00
28050	Biopsy of foot joint lining		2	446.00
28052	Biopsy of foot joint lining		2	446.00
28054	Biopsy of toe joint lining		2	446.00
28060	Partial removal, foot fascia		2	446.00

28062	Removal of foot fascia		3	510.00
28070	Removal of foot joint lining		3	510.00
28072	Removal of foot joint lining		3	510.00
28080	Removal of foot lesion		3	510.00
28086	Excise foot tendon sheath		2	446.00
28088	Excise foot tendon sheath		2	446.00
28090	Removal of foot lesion		3	510.00
28092	Removal of toe lesions		3	510.00
28100	Removal of ankle/heel lesion		2	446.00
28102	Remove/graft foot lesion		3	510.00
28103	Remove/graft foot lesion		3	510.00
28104	Removal of foot lesion		2	446.00
28106	Remove/graft foot lesion		3	510.00
28107	Remove/graft foot lesion		3	510.00
28108	Removal of toe lesions	A*	2	446.00
28110	Part removal of metatarsal		3	510.00
28111	Part removal of metatarsal		3	510.00
28112	Part removal of metatarsal		3	510.00
28113	Part removal of metatarsal		3	510.00
28114	Removal of metatarsal heads		3	510.00
28116	Revision of foot		3	510.00
28118	Removal of heel bone		4	630.00
28119	Removal of heel spur		4	630.00
28120	Part removal of ankle/heel		7	995.00
28122	Partial removal of foot bone		3	510.00
28126	Partial removal of toe		3	510.00
28130	Removal of ankle bone		3	510.00
28140	Removal of metatarsal		3	510.00
28150	Removal of toe		3	510.00
28153	Partial removal of toe		3	510.00
28160	Partial removal of toe		3	510.00
28171	Extensive foot surgery		3	510.00
28173	Extensive foot surgery		3	510.00
28175	Extensive foot surgery		3	510.00
28192	Removal of foot foreign body		2	446.00
28193	Removal of foot foreign body		4	630.00
28200	Repair of foot tendon		3	510.00
28202	Repair/graft of foot tendon		3	510.00
28208	Repair of foot tendon		3	510.00
28210	Repair/graft of foot tendon		3	510.00
28222	Release of foot tendons		1	333.00
28225	Release of foot tendon		1	333.00
28226	Release of foot tendons		1	333.00
28234	Incision of foot tendon		2	446.00
28238	Revision of foot tendon		3	510.00

28240	Release of big toe		2	446.00
28250	Revision of foot fascia		3	510.00
28260	Release of midfoot joint		3	510.00
28261	Revision of foot tendon		3	510.00
28262	Revision of foot and ankle		4	630.00
28264	Release of midfoot joint		1	333.00
28270	Release of foot contracture		3	510.00
28280	Fusion of toes		2	446.00
28285	Repair of hammertoe		3	510.00
28286	Repair of hammertoe		4	630.00
28288	Partial removal of foot bone		3	510.00
28289	Repair hallux rigidus		3	510.00
28290	Correction of bunion		2	446.00
28292	Correction of bunion		2	446.00
28293	Correction of bunion		3	510.00
28294	Correction of bunion		3	510.00
28296	Correction of bunion		3	510.00
28297	Correction of bunion		3	510.00
28298	Correction of bunion		3	510.00
28299	Correction of bunion		5	717.00
28300	Incision of heel bone		2	446.00
28302	Incision of ankle bone		2	446.00
28304	Incision of midfoot bones		2	446.00
28305	Incise/graft midfoot bones		3	510.00
28306	Incision of metatarsal		4	630.00
28307	Incision of metatarsal		4	630.00
28308	Incision of metatarsal		2	446.00
28309	Incision of metatarsals		4	630.00
28310	Revision of big toe		3	510.00
28312	Revision of toe		3	510.00
28313	Repair deformity of toe		2	446.00
28315	Removal of sesamoid bone		4	630.00
28320	Repair of foot bones		4	630.00
28322	Repair of metatarsals		4	630.00
28340	Resect enlarged toe tissue		4	630.00
28341	Resect enlarged toe		4	630.00
28344	Repair extra toe(s)		4	630.00
28345	Repair webbed toe(s)		4	630.00
28400	Treatment of heel fracture		1	333.00
28405	Treatment of heel fracture		2	446.00
28406	Treatment of heel fracture		2	446.00
28415	Treat heel fracture		3	510.00
28420	Treat/graft heel fracture		4	630.00
28435	Treatment of ankle fracture		2	446.00
28436	Treatment of ankle fracture		2	446.00

28445	Treat ankle fracture		3	510.00
28456	Treat midfoot fracture		2	446.00
28465	Treat midfoot fracture, each		3	510.00
28476	Treat metatarsal fracture		2	446.00
28485	Treat metatarsal fracture		4	630.00
28496	Treat big toe fracture		2	446.00
28505	Treat big toe fracture		3	510.00
28525	Treat toe fracture		3	510.00
28531	Treat sesamoid bone fracture		3	510.00
28545	Treat foot dislocation		1	333.00
28546	Treat foot dislocation		2	446.00
28555	Repair foot dislocation		2	446.00
28575	Treat foot dislocation		1	333.00
28576	Treat foot dislocation		3	510.00
28585	Repair foot dislocation		3	510.00
28605	Treat foot dislocation		1	333.00
28606	Treat foot dislocation		2	446.00
28615	Repair foot dislocation		3	510.00
28635	Treat toe dislocation		1	333.00
28636	Treat toe dislocation		3	510.00
28645	Repair toe dislocation		3	510.00
28665	Treat toe dislocation		1	333.00
28666	Treat toe dislocation		3	510.00
28675	Repair of toe dislocation		3	510.00
28705	Fusion of foot bones		4	630.00
28715	Fusion of foot bones		4	630.00
28725	Fusion of foot bones		4	630.00
28730	Fusion of foot bones		4	630.00
28735	Fusion of foot bones		4	630.00
28737	Revision of foot bones		5	717.00
28740	Fusion of foot bones		4	630.00
28750	Fusion of big toe joint		4	630.00
28755	Fusion of big toe joint		4	630.00
28760	Fusion of big toe joint		4	630.00
28810	Amputation toe & metatarsal		2	446.00
28820	Amputation of toe		2	446.00
28825	Partial amputation of toe		2	446.00
29800	Jaw arthroscopy/surgery		3	510.00
29804	Jaw arthroscopy/surgery		3	510.00
29805	Shoulder arthroscopy, dx		3	510.00
29806	Shoulder arthroscopy/surgery		3	510.00
29807	Shoulder arthroscopy/surgery		3	510.00
29819	Shoulder arthroscopy/surgery		3	510.00
29820	Shoulder arthroscopy/surgery		3	510.00
29821	Shoulder arthroscopy/surgery		3	510.00

29822	Shoulder arthroscopy/surgery		3	510.00
29823	Shoulder arthroscopy/surgery		3	510.00
29824	Shoulder arthroscopy/surgery		5	717.00
29825	Shoulder arthroscopy/surgery		3	510.00
29826	Shoulder arthroscopy/surgery		3	510.00
29827	Arthroscop rotator cuff repr		5	717.00
29830	Elbow arthroscopy		3	510.00
29834	Elbow arthroscopy/surgery		3	510.00
29835	Elbow arthroscopy/surgery		3	510.00
29836	Elbow arthroscopy/surgery		3	510.00
29837	Elbow arthroscopy/surgery		3	510.00
29838	Elbow arthroscopy/surgery		3	510.00
29840	Wrist arthroscopy		3	510.00
29843	Wrist arthroscopy/surgery		3	510.00
29844	Wrist arthroscopy/surgery		3	510.00
29845	Wrist arthroscopy/surgery		3	510.00
29846	Wrist arthroscopy/surgery		3	510.00
29847	Wrist arthroscopy/surgery		3	510.00
29848	Wrist endoscopy/surgery		9	1,339.00
29850	Knee arthroscopy/surgery		4	630.00
29851	Knee arthroscopy/surgery		4	630.00
29855	Tibial arthroscopy/surgery		4	630.00
29856	Tibial arthroscopy/surgery		4	630.00
29860	Hip arthroscopy, dx		4	630.00
29861	Hip arthroscopy/surgery		4	630.00
29862	Hip arthroscopy/surgery		9	1,339.00
29863	Hip arthroscopy/surgery		4	630.00
29870	Knee arthroscopy, dx		3	510.00
29871	Knee arthroscopy/drainage		3	510.00
29873	Knee arthroscopy/surgery	A	3	510.00
29874	Knee arthroscopy/surgery		3	510.00
29875	Knee arthroscopy/surgery		4	630.00
29876	Knee arthroscopy/surgery		4	630.00
29877	Knee arthroscopy/surgery		4	630.00
29879	Knee arthroscopy/surgery		3	510.00
29880	Knee arthroscopy/surgery		4	630.00
29881	Knee arthroscopy/surgery		4	630.00
29882	Knee arthroscopy/surgery		3	510.00
29883	Knee arthroscopy/surgery		3	510.00
29884	Knee arthroscopy/surgery		3	510.00
29885	Knee arthroscopy/surgery		3	510.00
29886	Knee arthroscopy/surgery		3	510.00
29887	Knee arthroscopy/surgery		3	510.00
29888	Knee arthroscopy/surgery		3	510.00
29889	Knee arthroscopy/surgery		3	510.00

29891	Ankle arthroscopy/surgery		3	510.00
29892	Ankle arthroscopy/surgery		3	510.00
29893	Scope, plantar fasciotomy		9	1,339.00
29894	Ankle arthroscopy/surgery		3	510.00
29895	Ankle arthroscopy/surgery		3	510.00
29897	Ankle arthroscopy/surgery		3	510.00
29898	Ankle arthroscopy/surgery		3	510.00
29899	Ankle arthroscopy/surgery		3	510.00
29900	Mcp joint arthroscopy, dx		3	510.00
29901	Mcp joint arthroscopy, surg		3	510.00
29902	Mcp joint arthroscopy, surg		3	510.00
30115	Removal of nose polyp(s)		2	446.00
30117	Removal of intranasal lesion		3	510.00
30118	Removal of intranasal lesion		3	510.00
30120	Revision of nose		1	333.00
30125	Removal of nose lesion		2	446.00
30130	Removal of turbinate bones		3	510.00
30140	Removal of turbinate bones		2	446.00
30150	Partial removal of nose		3	510.00
30160	Removal of nose		4	630.00
30220	Insert nasal septal button	A	3	510.00
30310	Remove nasal foreign body		1	333.00
30320	Remove nasal foreign body		2	446.00
30400	Reconstruction of nose		4	630.00
30410	Reconstruction of nose		5	717.00
30420	Reconstruction of nose		5	717.00
30430	Revision of nose		3	510.00
30435	Revision of nose		5	717.00
30450	Revision of nose		7	995.00
30460	Revision of nose		7	995.00
30462	Revision of nose		9	1,339.00
30465	Repair nasal stenosis		9	1,339.00
30520	Repair of nasal septum		4	630.00
30540	Repair nasal defect		5	717.00
30545	Repair nasal defect		5	717.00
30560	Release of nasal adhesions		2	446.00
30580	Repair upper jaw fistula		4	630.00
30600	Repair mouth/nose fistula		4	630.00
30620	Intranasal reconstruction		7	995.00
30630	Repair nasal septum defect		7	995.00
30801	Cauterization, inner nose		1	333.00
30802	Cauterization, inner nose		1	333.00
30903	Control of nosebleed		1	333.00
30905	Control of nosebleed		1	333.00
30906	Repeat control of nosebleed		1	333.00

30915	Ligation, nasal sinus artery		2	446.00
30920	Ligation, upper jaw artery		3	510.00
30930	Therapy, fracture of nose		4	630.00
31020	Exploration, maxillary sinus		2	446.00
31030	Exploration, maxillary sinus		3	510.00
31032	Explore sinus,remove polyps		4	630.00
31050	Exploration, sphenoid sinus		2	446.00
31051	Sphenoid sinus surgery		4	630.00
31070	Exploration of frontal sinus		2	446.00
31075	Exploration of frontal sinus		4	630.00
31080	Removal of frontal sinus		4	630.00
31081	Removal of frontal sinus		4	630.00
31084	Removal of frontal sinus		4	630.00
31085	Removal of frontal sinus		4	630.00
31086	Removal of frontal sinus		4	630.00
31087	Removal of frontal sinus		4	630.00
31090	Exploration of sinuses		5	717.00
31200	Removal of ethmoid sinus		2	446.00
31201	Removal of ethmoid sinus		5	717.00
31205	Removal of ethmoid sinus		3	510.00
31233	Nasal/sinus endoscopy, dx		2	446.00
31235	Nasal/sinus endoscopy, dx		1	333.00
31237	Nasal/sinus endoscopy, surg		2	446.00
31238	Nasal/sinus endoscopy, surg		1	333.00
31239	Nasal/sinus endoscopy, surg		4	630.00
31240	Nasal/sinus endoscopy, surg		2	446.00
31254	Revision of ethmoid sinus		3	510.00
31255	Removal of ethmoid sinus		5	717.00
31256	Exploration maxillary sinus		3	510.00
31267	Endoscopy, maxillary sinus		3	510.00
31276	Sinus endoscopy, surgical		3	510.00
31287	Nasal/sinus endoscopy, surg		3	510.00
31288	Nasal/sinus endoscopy, surg		3	510.00
31300	Removal of larynx lesion		5	717.00
31320	Diagnostic incision, larynx		2	446.00
31400	Revision of larynx		2	446.00
31420	Removal of epiglottis		2	446.00
31510	Laryngoscopy with biopsy		2	446.00
31511	Remove foreign body, larynx		2	446.00
31512	Removal of larynx lesion		2	446.00
31513	Injection into vocal cord		2	446.00
31515	Laryngoscopy for aspiration		1	333.00
31525	Diagnostic laryngoscopy		1	333.00
31526	Diagnostic laryngoscopy		2	446.00
31527	Laryngoscopy for treatment		1	333.00

31528	Laryngoscopy and dilation		2	446.00
31529	Laryngoscopy and dilation		2	446.00
31530	Operative laryngoscopy		2	446.00
31531	Operative laryngoscopy		3	510.00
31535	Operative laryngoscopy		2	446.00
31536	Operative laryngoscopy		3	510.00
31540	Operative laryngoscopy		3	510.00
31541	Operative laryngoscopy		4	630.00
31545	Remove vc lesion w/scope	A*	4	630.00
31546	Remove vc lesion scope/graft	A*	4	630.00
31560	Operative laryngoscopy		5	717.00
31561	Operative laryngoscopy		5	717.00
31570	Laryngoscopy with injection		2	446.00
31571	Laryngoscopy with injection		2	446.00
31576	Laryngoscopy with biopsy		2	446.00
31577	Remove foreign body, larynx		2	446.00
31578	Removal of larynx lesion		2	446.00
31580	Revision of larynx		5	717.00
31582	Revision of larynx		5	717.00
31585	Treat larynx fracture		1	333.00
31586	Treat larynx fracture		2	446.00
31588	Revision of larynx		5	717.00
31590	Reinnervate larynx		5	717.00
31595	Larynx nerve surgery		2	446.00
31603	Incision of windpipe	A	1	333.00
31611	Surgery/speech prosthesis		3	510.00
31612	Puncture/clear windpipe		1	333.00
31613	Repair windpipe opening		2	446.00
31614	Repair windpipe opening		2	446.00
31615	Visualization of windpipe		1	333.00
31622	Dx bronchoscope/wash		1	333.00
31623	Dx bronchoscope/brush		2	446.00
31624	Dx bronchoscope/lavage		2	446.00
31625	Bronchoscopy with biopsy		2	446.00
31628	Bronchoscopy with biopsy		2	446.00
31629	Bronchoscopy with biopsy		2	446.00
31630	Bronchoscopy with repair		2	446.00
31631	Bronchoscopy with dilation		2	446.00
31635	Remove foreign body, airway		2	446.00
31636	Bronchoscopy, bronch stents	A*	2	446.00
31637	Bronchoscopy, stent add-on	A*	1	333.00
31638	Bronchoscopy, revise stent	A*	2	446.00
31640	Bronchoscopy & remove lesion		2	446.00
31641	Bronchoscopy, treat blockage		2	446.00
31643	Diag bronchoscope/catheter		2	446.00

31645	Bronchoscopy, clear airways		1	333.00
31646	Bronchoscopy, reclear airway		1	333.00
31656	Bronchoscopy, inj for xray		1	333.00
31700	Insertion of airway catheter		1	333.00
31717	Bronchial brush biopsy		1	333.00
31720	Clearance of airways		1	333.00
31730	Intro, windpipe wire/tube		1	333.00
31750	Repair of windpipe		5	717.00
31755	Repair of windpipe		2	446.00
31820	Closure of windpipe lesion		1	333.00
31825	Repair of windpipe defect		2	446.00
31830	Revise windpipe scar		2	446.00
32000	Drainage of chest		1	333.00
32400	Needle biopsy chest lining		1	333.00
32405	Biopsy, lung or mediastinum		1	333.00
32420	Puncture/clear lung		1	333.00
33010	Drainage of heart sac		2	446.00
33011	Repeat drainage of heart sac		2	446.00
33212	Insertion of pulse generator	A*	3	510.00
33213	Insertion of pulse generator	A*	3	510.00
33222	Revise pocket, pacemaker		2	446.00
33223	Revise pocket, pacing-defib		2	446.00
33233	Removal of pacemaker system	A*	2	446.00
35188	Repair blood vessel lesion		4	630.00
35207	Repair blood vessel lesion		4	630.00
35875	Removal of clot in graft		9	1,339.00
35876	Removal of clot in graft		9	1,339.00
36260	Insertion of infusion pump		3	510.00
36261	Revision of infusion pump		2	446.00
36262	Removal of infusion pump		1	333.00
36475	Endovenous rf, 1st vein	A*	3	510.00
36476	Endovenous rf, vein add-on	A*	3	510.00
36478	Endovenous laser, 1st vein	A*	3	510.00
36479	Endovenous laser vein addon	A*	3	510.00
36555	Insert non-tunnel cv cath		1	333.00
36556	Insert non-tunnel cv cath		1	333.00
36557	Insert tunneled cv cath		2	446.00
36558	Insert tunneled cv cath		2	446.00
36560	Insert tunneled cv cath		3	510.00
36561	Insert tunneled cv cath		3	510.00
36563	Insert tunneled cv cath		3	510.00
36565	Insert tunneled cv cath		3	510.00
36566	Insert tunneled cv cath		3	510.00
36568	Insert tunneled cv cath		1	333.00
36569	Insert tunneled cv cath		1	333.00

36570	Insert tunneled cv cath		3	510.00
36571	Insert tunneled cv cath		3	510.00
36575	Repair tunneled cv cath		2	446.00
36576	Repair tunneled cv cath		2	446.00
36578	Replace tunneled cv cath		2	446.00
36580	Replace tunneled cv cath		1	333.00
36581	Replace tunneled cv cath		2	446.00
36582	Replace tunneled cv cath		3	510.00
36583	Replace tunneled cv cath		3	510.00
36584	Replace tunneled cv cath		1	333.00
36585	Replace tunneled cv cath		3	510.00
36589	Removal tunneled cv cath		1	333.00
36590	Removal tunneled cv cath		1	333.00
36640	Insertion catheter, artery		1	333.00
36800	Insertion of cannula		3	510.00
36810	Insertion of cannula		3	510.00
36815	Insertion of cannula		3	510.00
36819	Av fusion/uppr arm vein		3	510.00
36820	Av fusion/forearm vein		3	510.00
36821	Av fusion direct any site		3	510.00
36825	Artery-vein graft		4	630.00
36830	Artery-vein graft		4	630.00
36831	Open thrombect av fistula		9	1,339.00
36832	Av fistula revision, open		4	630.00
36833	Av fistula revision		4	630.00
36834	Repair AV aneurysm	A	3	510.00
36835	Artery to vein shunt		4	630.00
36860	External cannula declotting		2	446.00
36861	Cannula declotting		3	510.00
36870	Percut thrombect av fistula		9	1,339.00
37500	Endoscopy ligate perf veins	A	3	510.00
37607	Ligation of a-v fistula		3	510.00
37609	Temporal artery procedure		2	446.00
37650	Revision of major vein		2	446.00
37700	Revise leg vein		2	446.00
37720	Removal of leg vein		3	510.00
37730	Removal of leg veins		3	510.00
37735	Removal of leg veins/lesion		3	510.00
37760	Revision of leg veins		3	510.00
37780	Revision of leg vein		3	510.00
37785	Revise secondary varicosity		3	510.00
37790	Penile venous occlusion		3	510.00
38300	Drainage, lymph node lesion		1	333.00
38305	Drainage, lymph node lesion		2	446.00
38308	Incision of lymph channels		2	446.00

38500	Biopsy/removal, lymph nodes		2	446.00
38505	Needle biopsy, lymph nodes		1	333.00
38510	Biopsy/removal, lymph nodes		2	446.00
38520	Biopsy/removal, lymph nodes		2	446.00
38525	Biopsy/removal, lymph nodes		2	446.00
38530	Biopsy/removal, lymph nodes		2	446.00
38542	Explore deep node(s), neck		2	446.00
38550	Removal, neck/armpit lesion		3	510.00
38555	Removal, neck/armpit lesion		4	630.00
38570	Laparoscopy, lymph node biop		9	1,339.00
38571	Laparoscopy, lymphadenectomy		9	1,339.00
38572	Laparoscopy, lymphadenectomy		9	1,339.00
38740	Remove armpit lymph nodes		2	446.00
38745	Remove armpit lymph nodes		4	630.00
38760	Remove groin lymph nodes		2	446.00
40500	Partial excision of lip		2	446.00
40510	Partial excision of lip		2	446.00
40520	Partial excision of lip		2	446.00
40525	Reconstruct lip with flap		2	446.00
40527	Reconstruct lip with flap		2	446.00
40530	Partial removal of lip		2	446.00
40650	Repair lip		3	510.00
40652	Repair lip		3	510.00
40654	Repair lip		3	510.00
40700	Repair cleft lip/nasal		7	995.00
40701	Repair cleft lip/nasal		7	995.00
40720	Repair cleft lip/nasal		7	995.00
40761	Repair cleft lip/nasal		3	510.00
40801	Drainage of mouth lesion		2	446.00
40814	Excise/repair mouth lesion		2	446.00
40816	Excision of mouth lesion		2	446.00
40818	Excise oral mucosa for graft		1	333.00
40819	Excise lip or cheek fold		1	333.00
40831	Repair mouth laceration		1	333.00
40840	Reconstruction of mouth		2	446.00
40842	Reconstruction of mouth		3	510.00
40843	Reconstruction of mouth		3	510.00
40844	Reconstruction of mouth		5	717.00
40845	Reconstruction of mouth		5	717.00
41005	Drainage of mouth lesion		1	333.00
41006	Drainage of mouth lesion		1	333.00
41007	Drainage of mouth lesion		1	333.00
41008	Drainage of mouth lesion		1	333.00
41009	Drainage of mouth lesion		1	333.00
41010	Incision of tongue fold		1	333.00

41015	Drainage of mouth lesion		1	333.00
41016	Drainage of mouth lesion		1	333.00
41017	Drainage of mouth lesion		1	333.00
41018	Drainage of mouth lesion		1	333.00
41112	Excision of tongue lesion		2	446.00
41113	Excision of tongue lesion		2	446.00
41114	Excision of tongue lesion		2	446.00
41116	Excision of mouth lesion		1	333.00
41120	Partial removal of tongue		5	717.00
41250	Repair tongue laceration		2	446.00
41251	Repair tongue laceration		2	446.00
41252	Repair tongue laceration		2	446.00
41500	Fixation of tongue		1	333.00
41510	Tongue to lip surgery		1	333.00
41520	Reconstruction, tongue fold		2	446.00
41800	Drainage of gum lesion		1	333.00
41827	Excision of gum lesion		2	446.00
42000	Drainage mouth roof lesion		2	446.00
42107	Excision lesion, mouth roof		2	446.00
42120	Remove palate/lesion		4	630.00
42140	Excision of uvula		2	446.00
42145	Repair palate, pharynx/uvula		5	717.00
42180	Repair palate		1	333.00
42182	Repair palate		2	446.00
42200	Reconstruct cleft palate		5	717.00
42205	Reconstruct cleft palate		5	717.00
42210	Reconstruct cleft palate		5	717.00
42215	Reconstruct cleft palate		7	995.00
42220	Reconstruct cleft palate		5	717.00
42226	Lengthening of palate		5	717.00
42235	Repair palate		5	717.00
42260	Repair nose to lip fistula		4	630.00
42300	Drainage of salivary gland		1	333.00
42305	Drainage of salivary gland		2	446.00
42310	Drainage of salivary gland		1	333.00
42320	Drainage of salivary gland		1	333.00
42325	Create salivary cyst drain		2	446.00
42340	Removal of salivary stone		2	446.00
42405	Biopsy of salivary gland		2	446.00
42408	Excision of salivary cyst		3	510.00
42409	Drainage of salivary cyst		3	510.00
42410	Excise parotid gland/lesion		3	510.00
42415	Excise parotid gland/lesion		7	995.00
42420	Excise parotid gland/lesion		7	995.00
42425	Excise parotid gland/lesion		7	995.00

42440	Excise submaxillary gland		3	510.00
42450	Excise sublingual gland		2	446.00
42500	Repair salivary duct		3	510.00
42505	Repair salivary duct		4	630.00
42507	Parotid duct diversion		3	510.00
42508	Parotid duct diversion		4	630.00
42509	Parotid duct diversion		4	630.00
42510	Parotid duct diversion		4	630.00
42600	Closure of salivary fistula		1	333.00
42665	Ligation of salivary duct	A	7	995.00
42700	Drainage of tonsil abscess		1	333.00
42720	Drainage of throat abscess		1	333.00
42725	Drainage of throat abscess		2	446.00
42802	Biopsy of throat		1	333.00
42804	Biopsy of upper nose/throat		1	333.00
42806	Biopsy of upper nose/throat		2	446.00
42808	Excise pharynx lesion		2	446.00
42810	Excision of neck cyst		3	510.00
42815	Excision of neck cyst		5	717.00
42820	Remove tonsils and adenoids		3	510.00
42821	Remove tonsils and adenoids		5	717.00
42825	Removal of tonsils		4	630.00
42826	Removal of tonsils		4	630.00
42830	Removal of adenoids		4	630.00
42831	Removal of adenoids		4	630.00
42835	Removal of adenoids		4	630.00
42836	Removal of adenoids		4	630.00
42860	Excision of tonsil tags		3	510.00
42870	Excision of lingual tonsil		3	510.00
42890	Partial removal of pharynx		7	995.00
42892	Revision of pharyngeal walls		7	995.00
42900	Repair throat wound		1	333.00
42950	Reconstruction of throat		2	446.00
42955	Surgical opening of throat		2	446.00
42960	Control throat bleeding		1	333.00
42962	Control throat bleeding		2	446.00
42972	Control nose/throat bleeding		3	510.00
43200	Esophagus endoscopy		1	333.00
43201	Esoph scope w/submucous inj		1	333.00
43202	Esophagus endoscopy, biopsy		1	333.00
43204	Esophagus endoscopy & inject		1	333.00
43205	Esophagus endoscopy/ligation		1	333.00
43215	Esophagus endoscopy		1	333.00
43216	Esophagus endoscopy/lesion		1	333.00
43217	Esophagus endoscopy		1	333.00

43219	Esophagus endoscopy		1	333.00
43220	Esoph endoscopy, dilation		1	333.00
43226	Esoph endoscopy, dilation		1	333.00
43227	Esoph endoscopy, repair		2	446.00
43228	Esoph endoscopy, ablation		2	446.00
43231	Esoph endoscopy w/us exam		2	446.00
43232	Esoph endoscopy w/us fn bx		2	446.00
43234	Upper GI endoscopy, exam		1	333.00
43235	Uppr gi endoscopy, diagnosis		1	333.00
43236	Uppr gi scope w/submuc inj		2	446.00
43237	Endoscopic us exam, esoph	A*	2	446.00
43238	Uppr gi endoscopy w/us fn bx	A*	2	446.00
43239	Upper GI endoscopy, biopsy		2	446.00
43240	Esoph endoscope w/drain cyst		2	446.00
43241	Upper GI endoscopy with tube		2	446.00
43242	Uppr gi endoscopy w/us fn bx		2	446.00
43243	Upper gi endoscopy & inject		2	446.00
43244	Upper GI endoscopy/ligation		2	446.00
43245	Operative upper GI endoscopy		2	446.00
43246	Place gastrostomy tube		2	446.00
43247	Operative upper GI endoscopy		2	446.00
43248	Uppr gi endoscopy/guide wire		2	446.00
43249	Esoph endoscopy, dilation		2	446.00
43250	Upper GI endoscopy/tumor		2	446.00
43251	Operative upper GI endoscopy		2	446.00
43255	Operative upper GI endoscopy		2	446.00
43256	Uppr gi endoscopy w stent		3	510.00
43258	Operative upper GI endoscopy		3	510.00
43259	Endoscopic ultrasound exam		3	510.00
43260	Endo cholangiopancreatograph		2	446.00
43261	Endo cholangiopancreatograph		2	446.00
43262	Endo cholangiopancreatograph		2	446.00
43263	Endo cholangiopancreatograph		2	446.00
43264	Endo cholangiopancreatograph		2	446.00
43265	Endo cholangiopancreatograph		2	446.00
43267	Endo cholangiopancreatograph		2	446.00
43268	Endo cholangiopancreatograph		2	446.00
43269	Endo cholangiopancreatograph		2	446.00
43271	Endo cholangiopancreatograph		2	446.00
43272	Endo cholangiopancreatograph		2	446.00
43450	Dilate esophagus		1	333.00
43453	Dilate esophagus		1	333.00
43456	Dilate esophagus		2	446.00
43458	Dilate esophagus		2	446.00
43600	Biopsy of stomach		1	333.00

43653	Laparoscopy, gastrostomy		9	1,339.00
43750	Place gastrostomy tube		2	446.00
43760	Change gastrostomy tube		1	333.00
43870	Repair stomach opening		1	333.00
44100	Biopsy of bowel		1	333.00
44312	Revision of ileostomy		1	333.00
44340	Revision of colostomy		3	510.00
44360	Small bowel endoscopy		2	446.00
44361	Small bowel endoscopy/biopsy		2	446.00
44363	Small bowel endoscopy		2	446.00
44364	Small bowel endoscopy		2	446.00
44365	Small bowel endoscopy		2	446.00
44366	Small bowel endoscopy		2	446.00
44369	Small bowel endoscopy		2	446.00
44370	Small bowel endoscopy/stent		9	1,339.00
44372	Small bowel endoscopy		2	446.00
44373	Small bowel endoscopy		2	446.00
44376	Small bowel endoscopy		2	446.00
44377	Small bowel endoscopy/biopsy		2	446.00
44378	Small bowel endoscopy		2	446.00
44379	S bowel endoscope w/stent		9	1,339.00
44380	Small bowel endoscopy		1	333.00
44382	Small bowel endoscopy		1	333.00
44383	Ileoscopy w/stent		9	1,339.00
44385	Endoscopy of bowel pouch		1	333.00
44386	Endoscopy, bowel pouch/biop		1	333.00
44388	Colon endoscopy		1	333.00
44389	Colonoscopy with biopsy		1	333.00
44390	Colonoscopy for foreign body		1	333.00
44391	Colonoscopy for bleeding		1	333.00
44392	Colonoscopy & polypectomy		1	333.00
44393	Colonoscopy, lesion removal		1	333.00
44394	Colonoscopy w/snare		1	333.00
44397	Colonoscopy w/stent	A	1	333.00
45000	Drainage of pelvic abscess		1	333.00
45005	Drainage of rectal abscess		2	446.00
45020	Drainage of rectal abscess		2	446.00
45100	Biopsy of rectum		1	333.00
45108	Removal of anorectal lesion		2	446.00
45150	Excision of rectal stricture		2	446.00
45160	Excision of rectal lesion		2	446.00
45170	Excision of rectal lesion		2	446.00
45190	Destruction, rectal tumor		9	1,339.00
45305	Protosigmoidoscopy w/bx		1	333.00
45307	Protosigmoidoscopy fb		1	333.00

45308	Protosigmoidoscopy removal		1	333.00
45309	Protosigmoidoscopy removal		1	333.00
45315	Protosigmoidoscopy removal		1	333.00
45317	Protosigmoidoscopy bleed		1	333.00
45320	Protosigmoidoscopy ablate		1	333.00
45321	Protosigmoidoscopy volvul		1	333.00
45327	Proctosigmoidoscopy w/stent	A	1	333.00
45331	Sigmoidoscopy and biopsy		1	333.00
45332	Sigmoidoscopy w/fb removal		1	333.00
45333	Sigmoidoscopy & polypectomy		1	333.00
45334	Sigmoidoscopy for bleeding		1	333.00
45335	Sigmoidoscope w/submub inj		1	333.00
45337	Sigmoidoscopy & decompress		1	333.00
45338	Sigmoidoscpy w/tumr remove		1	333.00
45339	Sigmoidoscopy w/ablate tumr		1	333.00
45340	Sig w/balloon dilation		1	333.00
45341	Sigmoidoscopy w/ultrasound	A	1	333.00
45342	Sigmoidoscopy w/us guide bx	A	1	333.00
45345	Sigmoidoscopy w/stent	A	1	333.00
45355	Surgical colonoscopy		1	333.00
45378	Diagnostic colonoscopy		2	446.00
45379	Colonoscopy w/fb removal		2	446.00
45380	Colonoscopy and biopsy		2	446.00
45381	Colonoscope, submucous inj		2	446.00
45382	Colonoscopy/control bleeding		2	446.00
45383	Lesion removal colonoscopy		2	446.00
45384	Lesion remove colonoscopy		2	446.00
45385	Lesion removal colonoscopy		2	446.00
45386	Colonoscope dilate stricture		2	446.00
45387	Colonoscopy w/stent	A	1	333.00
45391	Colonoscopy w/endoscope us	A*	2	446.00
45392	Colonoscopy w/endoscopic fnb	A*	2	446.00
45500	Repair of rectum		2	446.00
45505	Repair of rectum		2	446.00
45560	Repair of rectocele		2	446.00
45900	Reduction of rectal prolapse		1	333.00
45905	Dilation of anal sphincter		1	333.00
45910	Dilation of rectal narrowing		1	333.00
45915	Remove rectal obstruction		1	333.00
46020	Placement of seton		3	510.00
46030	Removal of rectal marker		1	333.00
46040	Incision of rectal abscess		3	510.00
46045	Incision of rectal abscess		2	446.00
46050	Incision of anal abscess		1	333.00
46060	Incision of rectal abscess		2	446.00

46080	Incision of anal sphincter		3	510.00
46200	Removal of anal fissure		2	446.00
46210	Removal of anal crypt		2	446.00
46211	Removal of anal crypts		2	446.00
46220	Removal of anal tab		1	333.00
46230	Removal of anal tags	A*	1	333.00
46250	Hemorrhoidectomy		3	510.00
46255	Hemorrhoidectomy		3	510.00
46257	Remove hemorrhoids & fissure		3	510.00
46258	Remove hemorrhoids & fistula		3	510.00
46260	Hemorrhoidectomy		3	510.00
46261	Remove hemorrhoids & fissure		4	630.00
46262	Remove hemorrhoids & fistula		4	630.00
46270	Removal of anal fistula		3	510.00
46275	Removal of anal fistula		3	510.00
46280	Removal of anal fistula		4	630.00
46285	Removal of anal fistula		1	333.00
46288	Repair anal fistula		4	630.00
46608	Anoscopy/ remove for body		1	333.00
46610	Anoscopy/remove lesion		1	333.00
46611	Anoscopy		1	333.00
46612	Anoscopy/ remove lesions		1	333.00
46615	Anoscopy		2	446.00
46700	Repair of anal stricture		3	510.00
46706	Repr of anal fistula w/glue	A*	1	333.00
46750	Repair of anal sphincter		3	510.00
46753	Reconstruction of anus		3	510.00
46754	Removal of suture from anus		2	446.00
46760	Repair of anal sphincter		2	446.00
46761	Repair of anal sphincter		3	510.00
46762	Implant artificial sphincter		7	995.00
46917	Laser surgery, anal lesions		1	333.00
46922	Excision of anal lesion(s)		1	333.00
46924	Destruction, anal lesion(s)		1	333.00
46937	Cryotherapy of rectal lesion		2	446.00
46938	Cryotherapy of rectal lesion		2	446.00
46947	Hemorrhoidopexy by stapling	A*	3	510.00
47000	Needle biopsy of liver		1	333.00
47510	Insert catheter, bile duct		2	446.00
47511	Insert bile duct drain		9	1,339.00
47525	Change bile duct catheter		1	333.00
47530	Revise/reinsert bile tube		1	333.00
47552	Biliary endoscopy thru skin		2	446.00
47553	Biliary endoscopy thru skin		3	510.00
47554	Biliary endoscopy thru skin		3	510.00

47555	Biliary endoscopy thru skin		3	510.00
47556	Biliary endoscopy thru skin		9	1,339.00
47560	Laparoscopy w/cholangio		3	510.00
47561	Laparo w/cholangio/biopsy		3	510.00
47630	Remove bile duct stone		3	510.00
48102	Needle biopsy, pancreas		1	333.00
49080	Puncture, peritoneal cavity		2	446.00
49081	Removal of abdominal fluid		2	446.00
49085	Remove abdomen foreign body		2	446.00
49180	Biopsy, abdominal mass		1	333.00
49250	Excision of umbilicus		4	630.00
49320	Diag laparo separate proc		3	510.00
49321	Laparoscopy, biopsy		4	630.00
49322	Laparoscopy, aspiration		4	630.00
49419	Insrt abdom cath for chemotx	A*	1	333.00
49420	Insert abdominal drain		1	333.00
49421	Insert abdominal drain		1	333.00
49422	Remove perm cannula/catheter		1	333.00
49426	Revise abdomen-venous shunt		2	446.00
49495	Rpr ing hernia baby, reduc		4	630.00
49496	Rpr ing hernia baby, blocked		4	630.00
49500	Rpr ing hernia, init, reduce		4	630.00
49501	Rpr ing hernia, init blocked		9	1,339.00
49505	Rpr i/hern init reduc>5 yr		4	630.00
49507	Rpr i/hern init block>5 yr		9	1,339.00
49520	Rerepair ing hernia, reduce		7	995.00
49521	Rerepair ing hernia, blocked		9	1,339.00
49525	Repair ing hernia, sliding		4	630.00
49540	Repair lumbar hernia		2	446.00
49550	Rpr fem hernia, init, reduce		5	717.00
49553	Rpr fem hernia, init blocked		9	1,339.00
49555	Rerepair fem hernia, reduce		5	717.00
49557	Rerepair fem hernia, blocked		9	1,339.00
49560	Rpr ventral hern init, reduc		4	630.00
49561	Rpr ventral hern init, block		9	1,339.00
49565	Rerepair ventrl hern, reduce		4	630.00
49566	Rerepair ventrl hern, block		9	1,339.00
49568	Hernia repair w/mesh		7	995.00
49570	Rpr epigastric hern, reduce		4	630.00
49572	Rpr epigastric hern, blocked		9	1,339.00
49580	Rpr umbil hern, reduc <5 yr		4	630.00
49582	Rpr umbil hern, block < 5 yr		9	1,339.00
49585	Rpr umbil hern, reduc > 5 yr		4	630.00
49587	Rpr umbil hern, block > 5 yr		9	1,339.00
49590	Repair spigelian hernia		3	510.00

49600	Repair umbilical lesion		4	630.00
49650	Laparo hernia repair initial		4	630.00
49651	Laparo hernia repair recur		7	995.00
50200	Biopsy of kidney		1	333.00
50390	Drainage of kidney lesion		1	333.00
50392	Insert kidney drain		1	333.00
50393	Insert ureteral tube		1	333.00
50395	Create passage to kidney		1	333.00
50396	Measure kidney pressure		1	333.00
50398	Change kidney tube		1	333.00
50551	Kidney endoscopy		1	333.00
50553	Kidney endoscopy		1	333.00
50555	Kidney endoscopy & biopsy		1	333.00
50557	Kidney endoscopy & treatment		1	333.00
50559	Renal endoscopy/radiotracer		1	333.00
50561	Kidney endoscopy & treatment		1	333.00
50688	Change of ureter tube		1	333.00
50947	Laparo new ureter/bladder		9	1,339.00
50948	Laparo new ureter/bladder		9	1,339.00
50951	Endoscopy of ureter		1	333.00
50953	Endoscopy of ureter		1	333.00
50955	Ureter endoscopy & biopsy		1	333.00
50957	Ureter endoscopy & treatment		1	333.00
50959	Ureter endoscopy & tracer		1	333.00
50961	Ureter endoscopy & treatment		1	333.00
50970	Ureter endoscopy		1	333.00
50972	Ureter endoscopy & catheter		1	333.00
50974	Ureter endoscopy & biopsy		1	333.00
50976	Ureter endoscopy & treatment		1	333.00
50978	Ureter endoscopy & tracer		1	333.00
50980	Ureter endoscopy & treatment		1	333.00
51010	Drainage of bladder		1	333.00
51020	Incise & treat bladder		4	630.00
51030	Incise & treat bladder		4	630.00
51040	Incise & drain bladder		4	630.00
51045	Incise bladder/drain ureter		4	630.00
51050	Removal of bladder stone		4	630.00
51065	Remove ureter calculus		4	630.00
51080	Drainage of bladder abscess		1	333.00
51500	Removal of bladder cyst		4	630.00
51520	Removal of bladder lesion		4	630.00
51710	Change of bladder tube		1	333.00
51715	Endoscopic injection/implant		3	510.00
51726	Complex cystometrogram		1	333.00
51772	Urethra pressure profile		1	333.00

51785	Anal/urinary muscle study		1	333.00
51880	Repair of bladder opening		1	333.00
51992	Laparo sling operation	A*	5	717.00
52000	Cystoscopy		1	333.00
52001	Cystoscopy, removal of clots		2	446.00
52005	Cystoscopy & ureter catheter		2	446.00
52007	Cystoscopy and biopsy		2	446.00
52010	Cystoscopy & duct catheter		2	446.00
52204	Cystoscopy		2	446.00
52214	Cystoscopy and treatment		2	446.00
52224	Cystoscopy and treatment		2	446.00
52234	Cystoscopy and treatment		2	446.00
52235	Cystoscopy and treatment		3	510.00
52240	Cystoscopy and treatment		3	510.00
52250	Cystoscopy and radiotracer		4	630.00
52260	Cystoscopy and treatment		2	446.00
52270	Cystoscopy & revise urethra		2	446.00
52275	Cystoscopy & revise urethra		2	446.00
52276	Cystoscopy and treatment		3	510.00
52277	Cystoscopy and treatment		2	446.00
52281	Cystoscopy and treatment		2	446.00
52282	Cystoscopy, implant stent		9	1,339.00
52283	Cystoscopy and treatment		2	446.00
52285	Cystoscopy and treatment		2	446.00
52290	Cystoscopy and treatment		2	446.00
52300	Cystoscopy and treatment		2	446.00
52301	Cystoscopy and treatment	A*	3	510.00
52305	Cystoscopy and treatment		2	446.00
52310	Cystoscopy and treatment		2	446.00
52315	Cystoscopy and treatment		2	446.00
52317	Remove bladder stone		1	333.00
52318	Remove bladder stone		2	446.00
52320	Cystoscopy and treatment		5	717.00
52325	Cystoscopy, stone removal		4	630.00
52327	Cystoscopy, inject material		2	446.00
52330	Cystoscopy and treatment		2	446.00
52332	Cystoscopy and treatment		2	446.00
52334	Create passage to kidney		3	510.00
52341	Cysto w/ureter stricture tx		3	510.00
52342	Cysto w/up stricture tx		3	510.00
52343	Cysto w/renal stricture tx		3	510.00
52344	Cysto/uretero, stone remove		3	510.00
52345	Cysto/uretero w/up stricture		3	510.00
52346	Cystouretero w/renal strict		3	510.00
52351	Cystouretro & or pyeloscope		3	510.00

52352	Cystouretro w/stone remove		4	630.00
52353	Cystouretero w/lithotripsy		4	630.00
52354	Cystouretero w/biopsy		4	630.00
52355	Cystouretero w/excise tumor		4	630.00
52400	Cystouretero w/congen repr		3	510.00
52402	Cystourethro cut ejacul duct	A*	3	510.00
52450	Incision of prostate		3	510.00
52500	Revision of bladder neck		3	510.00
52510	Dilation prostatic urethra		3	510.00
52601	Prostatectomy (TURP)		4	630.00
52606	Control postop bleeding		1	333.00
52612	Prostatectomy, first stage		2	446.00
52614	Prostatectomy, second stage		1	333.00
52620	Remove residual prostate		1	333.00
52630	Remove prostate regrowth		2	446.00
52640	Relieve bladder contracture		2	446.00
52647	Laser surgery of prostate		9	1,339.00
52648	Laser surgery of prostate		9	1,339.00
52700	Drainage of prostate abscess		2	446.00
53000	Incision of urethra		1	333.00
53010	Incision of urethra		1	333.00
53020	Incision of urethra		1	333.00
53040	Drainage of urethra abscess		2	446.00
53080	Drainage of urinary leakage		3	510.00
53200	Biopsy of urethra		1	333.00
53210	Removal of urethra		5	717.00
53215	Removal of urethra		5	717.00
53220	Treatment of urethra lesion		2	446.00
53230	Removal of urethra lesion		2	446.00
53235	Removal of urethra lesion		3	510.00
53240	Surgery for urethra pouch		2	446.00
53250	Removal of urethra gland		2	446.00
53260	Treatment of urethra lesion		2	446.00
53265	Treatment of urethra lesion		2	446.00
53270	Removal of urethra gland		2	446.00
53275	Repair of urethra defect		2	446.00
53400	Revise urethra, stage 1		3	510.00
53405	Revise urethra, stage 2		2	446.00
53410	Reconstruction of urethra		2	446.00
53420	Reconstruct urethra, stage 1		3	510.00
53425	Reconstruct urethra, stage 2		2	446.00
53430	Reconstruction of urethra		2	446.00
53431	Reconstruct urethra/bladder		2	446.00
53440	Correct bladder function		2	446.00
53442	Remove perineal prosthesis		1	333.00

53444	Insert tandem cuff		2	446.00
53445	Insert uro/ves nck sphincter		1	333.00
53446	Remove uro sphincter		1	333.00
53447	Remove/replace ur sphincter		1	333.00
53449	Repair uro sphincter		1	333.00
53450	Revision of urethra		1	333.00
53460	Revision of urethra		1	333.00
53502	Repair of urethra injury		2	446.00
53505	Repair of urethra injury		2	446.00
53510	Repair of urethra injury		2	446.00
53515	Repair of urethra injury		2	446.00
53520	Repair of urethra defect		2	446.00
53605	Dilate urethra stricture		2	446.00
53665	Dilation of urethra		1	333.00
53850	Prostatic microwave thermotx	D	9	1,339.00
54000	Slitting of prepuce		2	446.00
54001	Slitting of prepuce		2	446.00
54015	Drain penis lesion		4	630.00
54057	Laser surg, penis lesion(s)		1	333.00
54060	Excision of penis lesion(s)		1	333.00
54065	Destruction, penis lesion(s)		1	333.00
54100	Biopsy of penis		1	333.00
54105	Biopsy of penis		1	333.00
54110	Treatment of penis lesion		2	446.00
54111	Treat penis lesion, graft		2	446.00
54112	Treat penis lesion, graft		2	446.00
54115	Treatment of penis lesion		1	333.00
54120	Partial removal of penis		2	446.00
54150	Circumcision		1	333.00
54152	Circumcision		1	333.00
54160	Circumcision		2	446.00
54161	Circumcision		2	446.00
54162	Lysis penil circumcis lesion		2	446.00
54163	Repair of circumcision		2	446.00
54164	Frenulotomy of penis		2	446.00
54205	Treatment of penis lesion		4	630.00
54220	Treatment of penis lesion		1	333.00
54300	Revision of penis		3	510.00
54304	Revision of penis		3	510.00
54308	Reconstruction of urethra		3	510.00
54312	Reconstruction of urethra		3	510.00
54316	Reconstruction of urethra		3	510.00
54318	Reconstruction of urethra		3	510.00
54322	Reconstruction of urethra		3	510.00
54324	Reconstruction of urethra		3	510.00

54326	Reconstruction of urethra		3	510.00
54328	Revise penis/urethra		3	510.00
54340	Secondary urethral surgery		3	510.00
54344	Secondary urethral surgery		3	510.00
54348	Secondary urethral surgery		3	510.00
54352	Reconstruct urethra/penis		3	510.00
54360	Penis plastic surgery		3	510.00
54380	Repair penis		3	510.00
54385	Repair penis		3	510.00
54400	Insert semi-rigid prosthesis		3	510.00
54401	Insert self-contd prosthesis		3	510.00
54405	Insert multi-comp penis pros		3	510.00
54406	Remove multi-comp penis pros		3	510.00
54408	Repair multi-comp penis pros		3	510.00
54410	Remove/replace penis prosth		3	510.00
54415	Remove self-contd penis pros		3	510.00
54416	Remv/repl penis contain pros		3	510.00
54420	Revision of penis		4	630.00
54435	Revision of penis		4	630.00
54440	Repair of penis		4	630.00
54450	Preputial stretching		1	333.00
54500	Biopsy of testis		1	333.00
54505	Biopsy of testis		1	333.00
54512	Excise lesion testis		2	446.00
54520	Removal of testis		3	510.00
54522	Orchiectomy, partial		3	510.00
54530	Removal of testis		4	630.00
54550	Exploration for testis		4	630.00
54600	Reduce testis torsion		4	630.00
54620	Suspension of testis		3	510.00
54640	Suspension of testis		4	630.00
54660	Revision of testis		2	446.00
54670	Repair testis injury		3	510.00
54680	Relocation of testis(es)		3	510.00
54690	Laparoscopy, orchiectomy		9	1,339.00
54700	Drainage of scrotum		2	446.00
54800	Biopsy of epididymis		1	333.00
54820	Exploration of epididymis		1	333.00
54830	Remove epididymis lesion		3	510.00
54840	Remove epididymis lesion		4	630.00
54860	Removal of epididymis		3	510.00
54861	Removal of epididymis		4	630.00
54900	Fusion of spermatic ducts		4	630.00
54901	Fusion of spermatic ducts		4	630.00
55040	Removal of hydrocele		3	510.00

55041	Removal of hydroceles		5	717.00
55060	Repair of hydrocele		4	630.00
55100	Drainage of scrotum abscess		1	333.00
55110	Explore scrotum		2	446.00
55120	Removal of scrotum lesion		2	446.00
55150	Removal of scrotum		1	333.00
55175	Revision of scrotum		1	333.00
55180	Revision of scrotum		2	446.00
55200	Incision of sperm duct		2	446.00
55250	Removal of sperm duct(s)		2	446.00
55400	Repair of sperm duct		1	333.00
55500	Removal of hydrocele		3	510.00
55520	Removal of sperm cord lesion		4	630.00
55530	Revise spermatic cord veins		4	630.00
55535	Revise spermatic cord veins		4	630.00
55540	Revise hernia & sperm veins		5	717.00
55550	Laparo ligate spermatic vein		9	1,339.00
55680	Remove sperm pouch lesion		1	333.00
55700	Biopsy of prostate		2	446.00
55705	Biopsy of prostate		2	446.00
55720	Drainage of prostate abscess		1	333.00
55725	Drainage of prostate abscess		2	446.00
55859	Percut/needle insert, pros		9	1,339.00
56440	Surgery for vulva lesion		2	446.00
56441	Lysis of labial lesion(s)		1	333.00
56515	Destroy vulva lesion/s compl		3	510.00
56620	Partial removal of vulva		5	717.00
56625	Complete removal of vulva		7	995.00
56700	Partial removal of hymen		1	333.00
56720	Incision of hymen		1	333.00
56740	Remove vagina gland lesion		3	510.00
56800	Repair of vagina		3	510.00
56810	Repair of perineum		5	717.00
57000	Exploration of vagina		1	333.00
57010	Drainage of pelvic abscess		2	446.00
57020	Drainage of pelvic fluid		2	446.00
57023	I & d vag hematoma, non-ob		1	333.00
57065	Destroy vag lesions, complex		1	333.00
57105	Biopsy of vagina		2	446.00
57130	Remove vagina lesion		2	446.00
57135	Remove vagina lesion		2	446.00
57155	Insert uteri tandems/ovoids	A*	2	446.00
57180	Treat vaginal bleeding		1	333.00
57200	Repair of vagina		1	333.00
57210	Repair vagina/perineum		2	446.00

57220	Revision of urethra		3	510.00
57230	Repair of urethral lesion		3	510.00
57240	Repair bladder & vagina		5	717.00
57250	Repair rectum & vagina		5	717.00
57260	Repair of vagina		5	717.00
57265	Extensive repair of vagina		7	995.00
57268	Repair of bowel bulge		3	510.00
57288	Repair bladder defect	A	5	717.00
57289	Repair bladder & vagina		5	717.00
57291	Construction of vagina		5	717.00
57300	Repair rectum-vagina fistula		3	510.00
57400	Dilation of vagina		2	446.00
57410	Pelvic examination		2	446.00
57415	Remove vaginal foreign body		2	446.00
57513	Laser surgery of cervix		2	446.00
57520	Conization of cervix		2	446.00
57522	Conization of cervix		2	446.00
57530	Removal of cervix		3	510.00
57550	Removal of residual cervix		3	510.00
57556	Remove cervix, repair bowel		5	717.00
57700	Revision of cervix		1	333.00
57720	Revision of cervix		3	510.00
57820	D & c of residual cervix		3	510.00
58120	Dilation and curettage		2	446.00
58145	Removal of uterus lesion		5	717.00
58346	Insert heyman uteri capsule	A*	2	446.00
58350	Reopen fallopian tube		3	510.00
58353	Endometr ablate, thermal		4	630.00
58545	Laparoscopic myomectomy		9	1,339.00
58546	Laparo-myomectomy, complex		9	1,339.00
58550	Laparo-asst vag hysterectomy		9	1,339.00
58555	Hysteroscopy, dx, sep proc		1	333.00
58558	Hysteroscopy, biopsy		3	510.00
58559	Hysteroscopy, lysis		2	446.00
58560	Hysteroscopy, resect septum		3	510.00
58561	Hysteroscopy, remove myoma		3	510.00
58562	Hysteroscopy, remove fb		3	510.00
58563	Hysteroscopy, ablation		4	630.00
58565	Hysteroscopy, sterilization	A*	4	630.00
58660	Laparoscopy, lysis		5	717.00
58661	Laparoscopy, remove adnexa		5	717.00
58662	Laparoscopy, excise lesions		5	717.00
58670	Laparoscopy, tubal cautery		3	510.00
58671	Laparoscopy, tubal block		3	510.00
58672	Laparoscopy, fimbrioplasty		5	717.00

58673	Laparoscopy, salpingostomy		5	717.00
58800	Drainage of ovarian cyst(s)		3	510.00
58820	Drain ovary abscess, open		3	510.00
58900	Biopsy of ovary(s)		3	510.00
58970	Retrieval of oocyte	A*	1	333.00
58974	Transfer of embryo	A*	1	333.00
58976	Transfer of embryo	A*	1	333.00
59160	D & c after delivery		3	510.00
59320	Revision of cervix		1	333.00
59812	Treatment of miscarriage		5	717.00
59820	Care of miscarriage		5	717.00
59821	Treatment of miscarriage		5	717.00
59840	Abortion		5	717.00
59841	Abortion		5	717.00
59870	Evacuate mole of uterus		5	717.00
59871	Remove cerclage suture		5	717.00
60000	Drain thyroid/tongue cyst		1	333.00
60200	Remove thyroid lesion		2	446.00
60280	Remove thyroid duct lesion		4	630.00
60281	Remove thyroid duct lesion		4	630.00
61020	Remove brain cavity fluid		1	333.00
61026	Injection into brain canal		1	333.00
61050	Remove brain canal fluid		1	333.00
61055	Injection into brain canal		1	333.00
61070	Brain canal shunt procedure		1	333.00
61215	Insert brain-fluid device		3	510.00
61790	Treat trigeminal nerve		3	510.00
61791	Treat trigeminal tract		3	510.00
61885	Implant neurostim one array		2	446.00
61886	Implant neurostim arrays		3	510.00
61888	Revise/remove neuroreceiver		1	333.00
62194	Replace/irrigate catheter		1	333.00
62225	Replace/irrigate catheter		1	333.00
62230	Replace/revise brain shunt		2	446.00
62263	Lysis epidural adhesions		1	333.00
62264	Epidural lysis on single day	A	1	333.00
62268	Drain spinal cord cyst		1	333.00
62269	Needle biopsy, spinal cord		1	333.00
62270	Spinal fluid tap, diagnostic		1	333.00
62272	Drain cerebro spinal fluid		1	333.00
62273	Treat epidural spine lesion		1	333.00
62280	Treat spinal cord lesion		1	333.00
62281	Treat spinal cord lesion		1	333.00
62282	Treat spinal canal lesion		1	333.00
62287	Percutaneous diskectomy		9	1,339.00

62294	Injection into spinal artery		3	510.00
62310	Inject spine c/t		1	333.00
62311	Inject spine l/s (cd)		1	333.00
62318	Inject spine w/cath, c/t		1	333.00
62319	Inject spine w/cath l/s (cd)		1	333.00
62350	Implant spinal canal cath		2	446.00
62355	Remove spinal canal catheter		2	446.00
62360	Insert spine infusion device		2	446.00
62361	Implant spine infusion pump		2	446.00
62362	Implant spine infusion pump		2	446.00
62365	Remove spine infusion device		2	446.00
63600	Remove spinal cord lesion		2	446.00
63610	Stimulation of spinal cord		1	333.00
63650	Implant neuroelectrodes		2	446.00
63660	Revise/remove neuroelectrode		1	333.00
63685	Implant neuroreceiver		2	446.00
63688	Revise/remove neuroreceiver		1	333.00
63744	Revision of spinal shunt		3	510.00
63746	Removal of spinal shunt		2	446.00
64410	Injection for nerve block		1	333.00
64415	Injection for nerve block		1	333.00
64417	Injection for nerve block		1	333.00
64420	Injection for nerve block		1	333.00
64421	Injection for nerve block		1	333.00
64430	Injection for nerve block		1	333.00
64470	Inj paravertebral c/t		1	333.00
64472	Inj paravertebral c/t add-on		1	333.00
64475	Inj paravertebral l/s		1	333.00
64476	Inj paravertebral l/s add-on		1	333.00
64479	Inj foramen epidural c/t		1	333.00
64480	Inj foramen epidural add-on		1	333.00
64483	Inj foramen epidural l/s		1	333.00
64484	Inj foramen epidural add-on		1	333.00
64510	Injection for nerve block		1	333.00
64517	N block inj, hypogastric plexus	A*	2	446.00
64520	Injection for nerve block		1	333.00
64530	Injection for nerve block		1	333.00
64553	Implant neuroelectrodes		1	333.00
64561	Implant neuroelectrodes	A*	3	510.00
64573	Implant neuroelectrodes		1	333.00
64575	Implant neuroelectrodes		1	333.00
64577	Implant neuroelectrodes		1	333.00
64580	Implant neuroelectrodes		1	333.00
64581	Implant neuroelectrodes	A*	3	510.00
64585	Revise/remove neuroelectrode		1	333.00

64590	Implant neuroreceiver		2	446.00
64595	Revise/remove neuroreceiver		1	333.00
64600	Injection treatment of nerve		1	333.00
64605	Injection treatment of nerve		1	333.00
64610	Injection treatment of nerve		1	333.00
64620	Injection treatment of nerve		1	333.00
64622	Destr paravertebrl nerve l/s		1	333.00
64623	Destr paravertebral n add-on		1	333.00
64626	Destr paravertebrl nerve c/t		1	333.00
64627	Destr paravertebral n add-on		1	333.00
64630	Injection treatment of nerve		2	446.00
64680	Injection treatment of nerve		2	446.00
64681	Injection treatment of nerve	A*	2	446.00
64702	Revise finger/toe nerve		1	333.00
64704	Revise hand/foot nerve		1	333.00
64708	Revise arm/leg nerve		2	446.00
64712	Revision of sciatic nerve		2	446.00
64713	Revision of arm nerve(s)		2	446.00
64714	Revise low back nerve(s)		2	446.00
64716	Revision of cranial nerve		3	510.00
64718	Revise ulnar nerve at elbow		2	446.00
64719	Revise ulnar nerve at wrist		2	446.00
64721	Carpal tunnel surgery		2	446.00
64722	Relieve pressure on nerve(s)		1	333.00
64726	Release foot/toe nerve		1	333.00
64727	Internal nerve revision		1	333.00
64732	Incision of brow nerve		2	446.00
64734	Incision of cheek nerve		2	446.00
64736	Incision of chin nerve		2	446.00
64738	Incision of jaw nerve		2	446.00
64740	Incision of tongue nerve		2	446.00
64742	Incision of facial nerve		2	446.00
64744	Incise nerve, back of head		2	446.00
64746	Incise diaphragm nerve		2	446.00
64771	Sever cranial nerve		2	446.00
64772	Incision of spinal nerve		2	446.00
64774	Remove skin nerve lesion		2	446.00
64776	Remove digit nerve lesion		3	510.00
64778	Digit nerve surgery add-on		2	446.00
64782	Remove limb nerve lesion		3	510.00
64783	Limb nerve surgery add-on		2	446.00
64784	Remove nerve lesion		3	510.00
64786	Remove sciatic nerve lesion		3	510.00
64787	Implant nerve end		2	446.00
64788	Remove skin nerve lesion		3	510.00

64790	Removal of nerve lesion		3	510.00
64792	Removal of nerve lesion		3	510.00
64795	Biopsy of nerve		2	446.00
64802	Remove sympathetic nerves		2	446.00
64821	Remove sympathetic nerves		4	630.00
64831	Repair of digit nerve		4	630.00
64832	Repair nerve add-on		1	333.00
64834	Repair of hand or foot nerve		2	446.00
64835	Repair of hand or foot nerve		3	510.00
64836	Repair of hand or foot nerve		3	510.00
64837	Repair nerve add-on		1	333.00
64840	Repair of leg nerve		2	446.00
64856	Repair/transpose nerve		2	446.00
64857	Repair arm/leg nerve		2	446.00
64858	Repair sciatic nerve		2	446.00
64859	Nerve surgery		1	333.00
64861	Repair of arm nerves		3	510.00
64862	Repair of low back nerves		3	510.00
64864	Repair of facial nerve		3	510.00
64865	Repair of facial nerve		4	630.00
64870	Fusion of facial/other nerve		4	630.00
64872	Subsequent repair of nerve		2	446.00
64874	Repair & revise nerve add-on		3	510.00
64876	Repair nerve/shorten bone		3	510.00
64885	Nerve graft, head or neck		2	446.00
64886	Nerve graft, head or neck		2	446.00
64890	Nerve graft, hand or foot		2	446.00
64891	Nerve graft, hand or foot		2	446.00
64892	Nerve graft, arm or leg		2	446.00
64893	Nerve graft, arm or leg		2	446.00
64895	Nerve graft, hand or foot		3	510.00
64896	Nerve graft, hand or foot		3	510.00
64897	Nerve graft, arm or leg		3	510.00
64898	Nerve graft, arm or leg		3	510.00
64901	Nerve graft add-on		2	446.00
64902	Nerve graft add-on		2	446.00
64905	Nerve pedicle transfer		2	446.00
64907	Nerve pedicle transfer		1	333.00
65091	Revise eye		3	510.00
65093	Revise eye with implant		3	510.00
65101	Removal of eye		3	510.00
65103	Remove eye/insert implant		3	510.00
65105	Remove eye/attach implant		4	630.00
65110	Removal of eye		5	717.00
65112	Remove eye/revise socket		7	995.00

65114	Remove eye/revise socket		7	995.00
65130	Insert ocular implant		3	510.00
65135	Insert ocular implant		2	446.00
65140	Attach ocular implant		3	510.00
65150	Revise ocular implant		2	446.00
65155	Reinsert ocular implant		3	510.00
65175	Removal of ocular implant		1	333.00
65235	Remove foreign body from eye		2	446.00
65260	Remove foreign body from eye		3	510.00
65265	Remove foreign body from eye		4	630.00
65270	Repair of eye wound		2	446.00
65272	Repair of eye wound		2	446.00
65275	Repair of eye wound		4	630.00
65280	Repair of eye wound		4	630.00
65285	Repair of eye wound		4	630.00
65290	Repair of eye socket wound		3	510.00
65400	Removal of eye lesion		1	333.00
65410	Biopsy of cornea		2	446.00
65420	Removal of eye lesion		2	446.00
65426	Removal of eye lesion		5	717.00
65710	Corneal transplant		7	995.00
65730	Corneal transplant		7	995.00
65750	Corneal transplant		7	995.00
65755	Corneal transplant		7	995.00
65770	Revise cornea with implant		7	995.00
65772	Correction of astigmatism		4	630.00
65775	Correction of astigmatism		4	630.00
65780	Ocular reconst, transplant	A*	5	717.00
65781	Ocular reconst, transplant	A*	5	717.00
65782	Ocular reconst, transplant	A*	5	717.00
65800	Drainage of eye		1	333.00
65805	Drainage of eye		1	333.00
65810	Drainage of eye		3	510.00
65815	Drainage of eye		2	446.00
65820	Relieve inner eye pressure	A*	1	333.00
65850	Incision of eye		4	630.00
65865	Incise inner eye adhesions		1	333.00
65870	Incise inner eye adhesions		4	630.00
65875	Incise inner eye adhesions		4	630.00
65880	Incise inner eye adhesions		4	630.00
65900	Remove eye lesion		5	717.00
65920	Remove implant of eye		7	995.00
65930	Remove blood clot from eye		5	717.00
66020	Injection treatment of eye		1	333.00
66030	Injection treatment of eye		1	333.00

66130	Remove eye lesion		7	995.00
66150	Glaucoma surgery		4	630.00
66155	Glaucoma surgery		4	630.00
66160	Glaucoma surgery		2	446.00
66165	Glaucoma surgery		4	630.00
66170	Glaucoma surgery		4	630.00
66172	Incision of eye		4	630.00
66180	Implant eye shunt		5	717.00
66185	Revise eye shunt		2	446.00
66220	Repair eye lesion		3	510.00
66225	Repair/graft eye lesion		4	630.00
66250	Follow-up surgery of eye		2	446.00
66500	Incision of iris		1	333.00
66505	Incision of iris		1	333.00
66600	Remove iris and lesion		3	510.00
66605	Removal of iris		3	510.00
66625	Removal of iris		3	510.00
66630	Removal of iris		3	510.00
66635	Removal of iris		3	510.00
66680	Repair iris & ciliary body		3	510.00
66682	Repair iris & ciliary body		2	446.00
66700	Destruction, ciliary body		2	446.00
66710	Destruction, ciliary body		2	446.00
66711	Ciliary endoscopic ablation	A*	2	446.00
66720	Destruction, ciliary body		2	446.00
66740	Destruction, ciliary body		2	446.00
66821	After cataract laser surgery		2	446.00
66825	Reposition intraocular lens		4	630.00
66830	Removal of lens lesion		4	630.00
66840	Removal of lens material		4	630.00
66850	Removal of lens material		7	995.00
66852	Removal of lens material		4	630.00
66920	Extraction of lens		4	630.00
66930	Extraction of lens		5	717.00
66940	Extraction of lens		5	717.00
66982	Cataract surgery, complex		8	973.00
66983	Cataract surg w/iol, 1 stage		8	973.00
66984	Cataract surg w/iol, i stage		8	973.00
66985	Insert lens prosthesis		6	826.00
66986	Exchange lens prosthesis		6	826.00
67005	Partial removal of eye fluid		4	630.00
67010	Partial removal of eye fluid		4	630.00
67015	Release of eye fluid		1	333.00
67025	Replace eye fluid		1	333.00
67027	Implant eye drug system		4	630.00

67030	Incise inner eye strands		1	333.00
67031	Laser surgery, eye strands		2	446.00
67036	Removal of inner eye fluid		4	630.00
67038	Strip retinal membrane		5	717.00
67039	Laser treatment of retina		7	995.00
67040	Laser treatment of retina		7	995.00
67107	Repair detached retina		5	717.00
67108	Repair detached retina		7	995.00
67112	Rerepair detached retina		7	995.00
67115	Release encircling material		2	446.00
67120	Remove eye implant material		2	446.00
67121	Remove eye implant material		2	446.00
67141	Treatment of retina		2	446.00
67218	Treatment of retinal lesion		5	717.00
67227	Treatment of retinal lesion		1	333.00
67250	Reinforce eye wall		3	510.00
67255	Reinforce/graft eye wall		3	510.00
67311	Revise eye muscle		3	510.00
67312	Revise two eye muscles		4	630.00
67314	Revise eye muscle		4	630.00
67316	Revise two eye muscles		4	630.00
67318	Revise eye muscle(s)		4	630.00
67320	Revise eye muscle(s) add-on		4	630.00
67331	Eye surgery follow-up add-on		4	630.00
67332	Rerevise eye muscles add-on		4	630.00
67334	Revise eye muscle w/suture		4	630.00
67335	Eye suture during surgery		4	630.00
67340	Revise eye muscle add-on		4	630.00
67343	Release eye tissue	A	7	995.00
67350	Biopsy eye muscle		1	333.00
67400	Explore/biopsy eye socket		3	510.00
67405	Explore/drain eye socket		4	630.00
67412	Explore/treat eye socket		5	717.00
67413	Explore/treat eye socket		5	717.00
67415	Aspiration, orbital contents		1	333.00
67420	Explore/treat eye socket		5	717.00
67430	Explore/treat eye socket		5	717.00
67440	Explore/drain eye socket		5	717.00
67445	Explr/decompress eye socket	A*	5	717.00
67450	Explore/biopsy eye socket		5	717.00
67550	Insert eye socket implant		4	630.00
67560	Revise eye socket implant		2	446.00
67570	Decompress optic nerve	A*	4	630.00
67715	Incision of eyelid fold		1	333.00
67808	Remove eyelid lesion(s)		2	446.00

67830	Revise eyelashes		2	446.00
67835	Revise eyelashes		2	446.00
67880	Revision of eyelid		3	510.00
67882	Revision of eyelid		3	510.00
67900	Repair brow defect		4	630.00
67901	Repair eyelid defect		5	717.00
67902	Repair eyelid defect		5	717.00
67903	Repair eyelid defect		4	630.00
67904	Repair eyelid defect		4	630.00
67906	Repair eyelid defect		5	717.00
67908	Repair eyelid defect		4	630.00
67909	Revise eyelid defect		4	630.00
67911	Revise eyelid defect		3	510.00
67912	Correction eyelid w/implant	A*	3	510.00
67914	Repair eyelid defect		3	510.00
67916	Repair eyelid defect		4	630.00
67917	Repair eyelid defect		4	630.00
67921	Repair eyelid defect		3	510.00
67923	Repair eyelid defect		4	630.00
67924	Repair eyelid defect		4	630.00
67935	Repair eyelid wound		2	446.00
67950	Revision of eyelid		2	446.00
67961	Revision of eyelid		3	510.00
67966	Revision of eyelid		3	510.00
67971	Reconstruction of eyelid		3	510.00
67973	Reconstruction of eyelid		3	510.00
67974	Reconstruction of eyelid		3	510.00
67975	Reconstruction of eyelid		3	510.00
68115	Remove eyelid lining lesion		2	446.00
68130	Remove eyelid lining lesion		2	446.00
68320	Revise/graft eyelid lining		4	630.00
68325	Revise/graft eyelid lining		4	630.00
68326	Revise/graft eyelid lining		4	630.00
68328	Revise/graft eyelid lining		4	630.00
68330	Revise eyelid lining		4	630.00
68335	Revise/graft eyelid lining		4	630.00
68340	Separate eyelid adhesions		4	630.00
68360	Revise eyelid lining		2	446.00
68362	Revise eyelid lining		2	446.00
68371	Harvest eye tissue, alograft	A*	2	446.00
68500	Removal of tear gland		3	510.00
68505	Partial removal, tear gland		3	510.00
68510	Biopsy of tear gland		1	333.00
68520	Removal of tear sac		3	510.00
68525	Biopsy of tear sac		1	333.00

68540	Remove tear gland lesion		3	510.00
68550	Remove tear gland lesion		3	510.00
68700	Repair tear ducts		2	446.00
68720	Create tear sac drain		4	630.00
68745	Create tear duct drain		4	630.00
68750	Create tear duct drain		4	630.00
68770	Close tear system fistula		4	630.00
68810	Probe nasolacrimal duct		1	333.00
68811	Probe nasolacrimal duct		2	446.00
68815	Probe nasolacrimal duct		2	446.00
69110	Remove external ear, partial		1	333.00
69120	Removal of external ear		2	446.00
69140	Remove ear canal lesion(s)		2	446.00
69145	Remove ear canal lesion(s)		2	446.00
69150	Extensive ear canal surgery		3	510.00
69205	Clear outer ear canal		1	333.00
69300	Revise external ear		3	510.00
69310	Rebuild outer ear canal		3	510.00
69320	Rebuild outer ear canal		7	995.00
69421	Incision of eardrum		3	510.00
69436	Create eardrum opening		3	510.00
69440	Exploration of middle ear		3	510.00
69450	Eardrum revision		1	333.00
69501	Mastoidectomy		7	995.00
69502	Mastoidectomy		7	995.00
69505	Remove mastoid structures		7	995.00
69511	Extensive mastoid surgery		7	995.00
69530	Extensive mastoid surgery		7	995.00
69550	Remove ear lesion		5	717.00
69552	Remove ear lesion		7	995.00
69601	Mastoid surgery revision		7	995.00
69602	Mastoid surgery revision		7	995.00
69603	Mastoid surgery revision		7	995.00
69604	Mastoid surgery revision		7	995.00
69605	Mastoid surgery revision		7	995.00
69620	Repair of eardrum		2	446.00
69631	Repair eardrum structures		5	717.00
69632	Rebuild eardrum structures		5	717.00
69633	Rebuild eardrum structures		5	717.00
69635	Repair eardrum structures		7	995.00
69636	Rebuild eardrum structures		7	995.00
69637	Rebuild eardrum structures		7	995.00
69641	Revise middle ear & mastoid		7	995.00
69642	Revise middle ear & mastoid		7	995.00
69643	Revise middle ear & mastoid		7	995.00

69644	Revise middle ear & mastoid		7	995.00
69645	Revise middle ear & mastoid		7	995.00
69646	Revise middle ear & mastoid		7	995.00
69650	Release middle ear bone		7	995.00
69660	Revise middle ear bone		5	717.00
69661	Revise middle ear bone		5	717.00
69662	Revise middle ear bone		5	717.00
69666	Repair middle ear structures		4	630.00
69667	Repair middle ear structures		4	630.00
69670	Remove mastoid air cells		3	510.00
69676	Remove middle ear nerve		3	510.00
69700	Close mastoid fistula		3	510.00
69711	Remove/repair hearing aid		1	333.00
69714	Implant temple bone w/stimul		9	1,339.00
69715	Temple bne implnt w/stimulat		9	1,339.00
69717	Temple bone implant revision		9	1,339.00
69718	Revise temple bone implant		9	1,339.00
69720	Release facial nerve		5	717.00
69725	Release facial nerve	D	5	717.00
69740	Repair facial nerve		5	717.00
69745	Repair facial nerve		5	717.00
69801	Incise inner ear		5	717.00
69802	Incise inner ear		7	995.00
69805	Explore inner ear		7	995.00
69806	Explore inner ear		7	995.00
69820	Establish inner ear window		5	717.00
69840	Revise inner ear window		5	717.00
69905	Remove inner ear		7	995.00
69910	Remove inner ear & mastoid		7	995.00
69915	Incise inner ear nerve		7	995.00
69930	Implant cochlear device		7	995.00
G0105	Colorectal scrn; hi risk ind		2	446.00
G0121	Colon ca scrn; not high rsk ind		2	446.00
G0260	Inj for sacroiliac jt anesth		1	333.00